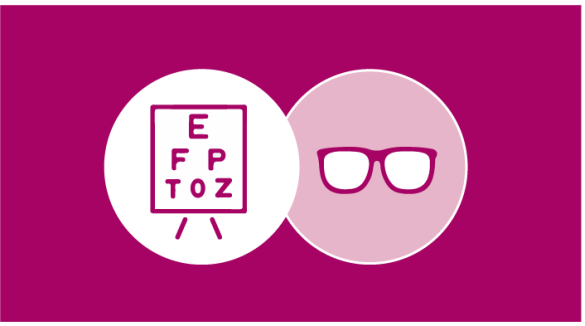

2023

Oregon Group Vision Plan

OEBB
Quartz Plan

Effective Date: October 1, 2023
Group Number: 100000016

Health plans in Oregon administered by Moda Health Plan, Inc.

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SECTION 1. WELCOME TO MODA HEALTH

We are pleased OEBB has chosen Moda Health to administer its vision benefit plan. This handbook will give you important information about the 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 website, Member Dashboard, at www.modahealth.com/oebb. 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 OEBB or Moda Health, without your agreement. You can find the most current handbook on your Member Dashboard. All plan provisions are governed by OEBB's benefit plan document with Moda Health and this handbook. 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.

Members may call customer service at 866-923-0409 or email OEBBQuestions@modahealth.com to request a hardcopy of this handbook free of charge.

This Plan is not a Medicare Supplement plan. Persons who are eligible for Medicare should review the Guide to Health Insurance for People with Medicare available from the Group.

SECTION 2. MEMBER RESOURCES

2.1 CONTACT INFORMATION

Moda Health Website (log in to your **Member Dashboard**)
www.modahealth.com
Some of the things you can do on your Member Dashboard are:
Find an in-network provider with Find Care
See how your claims were paid

Customer Service Department
866-923-0409
En español 888-786-7461
OEBBQuestions@modahealth.com

Appeals Department
601 SW 2nd Ave., Portland, OR 97204
Fax 503-412-4003
OregonExternalReview@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 NETWORK INFORMATION

When you use an in-network vision provider , you will receive quality vision care and will maximize your benefits. Use Find Care on your Member Dashboard to choose an in-network provider. You may contact Customer Service if you need help.

Network
Medical network is Connexus for residents in Oregon and southwest Washington

Out-of-Area Networks
Members who live in Alaska: First Health Network
Members who live in Idaho: Connexus and First Health Network

Members who live in all other states: Aetna PPO Network

All members will access the Connexus network only when seeking care within the Connexus service area.

2.4 OTHER RESOURCES

You can find other general information about the Plan in Section 10.

SECTION 3. BENEFIT DESCRIPTION

The Plan pays up to a maximum of $250 every plan year. A routine eye exam and one pair of corrective lenses for eyeglasses are covered every plan year. One pair of frames is covered every plan year for members under age 17 and every 2 plan years for members 17 years and older.

For an in-network provider, covered benefits are reimbursed at 100% of the provider's contracted fee. For an out-of-network provider, covered benefits are reimbursed at 100% of billed charges. Total reimbursements are limited to the plan maximum of $250. There is no deductible for covered services.

3.1 COVERED PROVIDERS

You may see any licensed ophthalmologist or licensed optometrist for these services. Glasses may also be provided by any licensed opticianor hardware provider

We have many in-network vision providers you can choose from (see section 2.3). When you choose in-network vision providers, it helps lower your costs.

We pay in-network providers based on the contracted fee (the amount the provider has agreed to accept for a particular service). Out-of-network providers are paid based on their billed charges.

3.2 COVERED SERVICES AND SUPPLIES

We cover these services:

a. Complete eye exam, including refraction
b. Frames for corrective lenses
c. Corrective lenses for eyeglasses or contact lenses.

Covered lenses include:

a. Single vision
b. Multifocal (bifocal)
c. Trifocal, Progressive, , Lenticular
d. Standard polycarbonate lenses
e. Contact lenses (disposable or conventional)
f. Oversized
g. Tinted, any color

SECTION 4. EXCLUSIONS

This section lists Plan exclusions. These are in addition to the limitations and exclusions that are described in other sections. These services, procedures and conditions are not covered, even if they are medically necessary or are recommended, referred, or provided by a vision provider. Treatment of a complication or consequence that happens because of an exclusion is not covered.

Benefits Not Stated
Services and supplies not included in this handbook as covered expenses

Experimental or Investigational Procedures
Including expenses related to or needed because of such procedures (see definition of experimental/investigational in Section 9)

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

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

Medical or Surgical Treatment of the Eyes or Supporting Structures

Missed Appointments

Nonprescription Lenses
Including nonprescription sunglasses

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

Safety Lenses
Unless lenses are corrective

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 veteran's coverage

Services Otherwise Available
Including those:

a. for which payment could be obtained in whole or in part if a member had applied for payment under any city, county, state, or federal law, except for Medicaid coverage
b. for which a member cannot be held liable because of an agreement between the vision provider and another third party payer that has paid or is obligated to pay for such service or supply

c. for which no charge is made, or for which no charge is normally made in the absence of coverage, including an expense a member did not have to pay due to discounts received or other promotions
d. provided under separate contracts that are used to provide coordinated coverage for covered persons in a group and are considered parts of the same plan
e. a member could have received in a hospital or program operated by a government agency or authority. This exclusion does not apply to:
    i. covered services rendered at any hospital owned or operated by the state of Oregon
    ii. veterans of the armed forces, in which case covered services and supplies furnished by the Veterans' Administration of the United States that are not service related are eligible for payment according to the terms of the Plan

Services Provided or Ordered by a Family Member
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

Special Procedures
Such as orthoptics low vision therapy, and vision training

Surgery to Correct Vision
Any procedure that alters the refractive character of the eye, the purpose of which is to cure or reduce near-sightedness, far-sightedness or astigmatism. Includes reversals or revisions, and treating any complications of these procedures.

Taxes

Telehealth

Third Party Liability Claims
Services and supplies to treat a vision condition that a third party is or may be responsible for, to the extent of any recovery received from or on behalf of the third party (see section 7.3.2)

Treatment After Coverage Ends

Treatment Before Coverage Begins

Treatment Not Medically Necessary
Including services or supplies that are:

a. Not medically necessary to treat a condition otherwise covered under the Plan
b. Inappropriate or inconsistent with the symptoms or diagnosis of your condition
c. Not established as the standard treatment by the medical community
d. Primarily for your convenience or that of a provider

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

Vision Care Related Procedures and Services
Including charges for:

a. Special procedures such as orthoptics and vision training
b. Subnormal vision aids and any associated supplemental testing
c. Lenses with prisms, prism segs, slab-off and other special-purpose vision aids
d. Plain nonprescription lenses and nonprescription sunglasses
e. Medical or surgical treatment of the eyes or supporting structures
f. Hard and/or scratch resisting coatings
g. Ultraviolet (UV) coating
h. Standard anti-reflective coating
i. Any expense a member did not have to pay due to discounts received or other promotions
j. Examination or corrective eyewear required by an employer and safety eyewear unless specifically covered
k. Lost or broken materials except at normal covered intervals
l. Replacement of lenses and frames unless the member is otherwise eligible

Work Related Conditions
Treatment of a vision condition you get because of your employment or self-employment, even if the expense is denied as not work-related 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 5. ELIGIBILITY

The Plan's eligibility rules are outlined in the Oregon Administrative Rules under OAR 111-015-0001. The date a person becomes eligible may be different than the date coverage begins. More specific information can be found under the Enrollment section (see Section 6).

5.1 ELIGIBILITY AUDIT

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

SECTION 6. ENROLLMENT

6.1 NEWLY HIRED AND NEWLY-ELIGIBLE ACTIVE ELIGIBLE EMPLOYEES

The Plan's enrollment rules for newly-hired and newly-eligible active eligible employees are outlined in the Oregon Administrative Rules under OAR 111-040-0010.

6.2 QUALIFIED STATUS CHANGES

The Plan's enrollment rules for qualified status changes are outlined in the Oregon Administrative Rules under OAR 111-040-0040.

Eligible employees and their spouse, domestic partner, and children may also have additional enrollment rights under the Children's Health Insurance Program Reauthorization Act of 2009. If prior coverage was under Medicaid or a children's health insurance program (CHIP) and such coverage was terminated due to loss of eligibility. Special enrollment must be requested within 60 days of the termination.

Additionally, if an eligible employee, spouse, domestic partner or child covered under Medicaid or CHIP becomes eligible for a premium assistance subsidy, and special enrollment is requested within 60 days of the determination of eligibility, they may enroll in the Plan outside of the open enrollment period.

The special enrollment rights as described above apply:

a. To an eligible employee who loses other coverage or becomes eligible for a premium assistance subsidy
b. To a spouse, domestic partner, or child who loses coverage under the other plan or becomes eligible for a premium assistance subsidy
c. To both an eligible employee and their dependent if neither is enrolled in the Plan, and either loses coverage under the other plan or becomes eligible for a premium assistance subsidy

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

Note: Enrolling a new dependent may cause a premium increase. Premiums will be adjusted accordingly. Such adjustments will apply during the first 60 days of coverage for newborn or adopted children. If payment is required but not received, the child will not be covered. Proof of legal guardianship will be required for coverage of a grandchild beyond the first 60 days from birth.

6.3 EFFECTIVE DATES

The Plan's effective dates for enrollment are outlined in the Oregon Administrative Rules under OAR 111-040-0001.

6.4 OPEN ENROLLMENT

The Plan's open enrollment rules are outlined in the Oregon Administrative Rules under OAR 111-040-0020.

6.5 LATE ENROLLMENT

The Plan's late enrollment rules are outlined in the Oregon Administrative Rules under OAR 111-040-0030.

6.6 RETURNING TO ACTIVE ELIGIBLE EMPLOYEE STATUS

The Plan's enrollment rules for those individuals returning to active eligible employee status are outlined in the Oregon Administrative Rules under OAR 111-040-0035.

All plan provisions will resume at re-enrollment whether or not there was a lapse in coverage. Any exclusion period that was not completed at the time the subscriber was laid off or had a reduction in hours must be satisfied. However, the period of layoff or reduction in hours will be counted toward the exclusion period. Upon re-enrollment in the Plan, any waiting period required by the Plan will not have to be re-served.

6.7 REMOVING AN INELIGIBLE INDIVIDUAL FROM BENEFIT PLANS

The Plan's rules for removing an ineligible individual from the Plan are outlined in the Oregon Administrative Rules under OAR 111-040-0015.

6.8 WHEN COVERAGE ENDS

Termination dates for loss of eligibility, death of the active eligible employee, and retirement of the active eligible employee are outlined in the Oregon Administrative Rules under OAR 111-040-0005. When the subscriber's coverage ends, coverage for all enrolled dependents also ends. In addition, there are a variety of other circumstances in which a member's coverage will end. These are described in the following paragraphs.

6.8.1 The Group Plan Ends

If the Plan is terminated for any reason, coverage ends for the participating organization, and members on the date the Plan ends.

6.8.2 Subscriber Ends Coverage

A subscriber may end their coverage, or coverage for any enrolled dependent, by giving Moda Health written notice through OEBB, in accordance with OEBB's Administration Rules. Coverage will end on the last day of the month through which premiums are paid.

6.8.3 Rescission

The Plan's enrollment rules for rescission by the Plan are outlined in OEBB's Administrative Rules.

6.8.4 Continuing Coverage

Information is in Continuation of Vision Coverage (Section 8).

6.9 DECLINATION OF COVERAGE

The Plan's rules for declining coverage are outlined in the Oregon Administrative Rules under OAR 111-040-0050.

SECTION 7. CLAIMS ADMINISTRATION & PAYMENT

7.1 SUBMISSION & PAYMENT OF CLAIMS

What to know about sending us a claim:

a. We must receive your claim 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 3 years after the date of service

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.

7.1.1 How to Send Us Claims

Sometimes you will have to pay a vision provider up front. When you are billed by the vision 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

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

7.1.2 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 or deny them. If all or part of a claim is denied, we will twll 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. You claim will not be paid unless we receive it within the claim submission period explained in section 7.1.

7.1.3 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.

7.2 APPEALS

Before you file an appeal, call the Health Navigator team. We may be able to solve your problem over the phone.

7.2.1 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

7.2.2 The Review Process

The Plan has a 2-level internal review process, a first level appeal and a second level appeal.

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 personal health information (PHI) allowing your representative to act for you. 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. We will send you a letter no more than 7 days after we receive your appeal so you know we got it
c. Someone who was not involved in the original decision will investigate your appeal
d. We will send the decision to you within 30 days

Special Circumstances

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.

7.2.3 Definitions

For purposes of section 7.2, 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 6.8.3)
b. Eligibility to participate in the Plan
c. Utilization review (described below)

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

Authorized Representative means an individual who by law or by the consent of a person may act on behalf of the person.

Complaint means an expression of dissatisfaction about a specific problem a member has encountered or about a decision by Moda Health or an agent acting on behalf of Moda Health, and which includes a request for action to resolve the problem or change the decision. A complaint does not include a request for information or clarification about any subject related to the Plan.

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

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

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

7.3 BENEFITS AVAILABLE FROM OTHER SOURCES

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

7.3.1 Coordination of Benefits (COB)

Coordination of benefits applies when you have vision 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. The Plan follows the order of benefit determination rules in the Oregon Administrative Rules. These rules decide which plan is primary and pays a claim for benefits first.

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

7.3.1.1 When this Plan Pays First

This Plan is primary and will pay first if the claim is for:

a. The subscriber's own vision expenses
b. Your covered child's expenses when you are the subscriber and
    a. Your birthday falls earlier in the calendar year than the other parent's and you are married, domestic partners or living together, or if there is a court decree assigning joint custody without specifying that one parent is responsible for healthcare expenses
    b. You are separated, divorced or not living together and you have informed us of a court decree that makes you responsible for the child's healthcare expenses
    c. If you are separated, divorced or not living together. There is not a court decree, but you have custody of the child

If you are a covered child on this Plan and also covered by your spouse's or domestic partner's plan, the plan that has covered you the longest is primary.

7.3.1.2 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 vision 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. An example is if the primary plan did not cover an expense because you did not get prior authorization when it was required

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 Oregon's COB rules is always primary.

7.3.1.3 Definitions

For purposes of section 7.3.1, the following definitions apply:

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

a. Group or individual insurance contracts and group-type contracts
b. HMO (health maintenance organization) coverage
c. Coverage under a labor-management trusteed plan, a union welfare plan, an employer organization plan or an employee benefits plan
d. Medicare or other government programs, other than Medicaid, and any other coverage required or provided by law
e. Other arrangements of insured or self-insured 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. Fixed indemnity coverage
b. Accident-only or school accident coverage
c. Specified disease or specified accident coverage

d. Benefits for non-medical components of group long-term care policies
e. Medicare supplement policies
f. Medicaid policies
g. Coverage under other federal governmental plans, unless permitted by law

Allowable expense is a vision 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 will also be considered an allowable expense and a benefit paid.

These are not allowable expenses:
a. Any expense that is not covered by any plan covering you
b. Any expense a provider is not allowed to charge you

7.3.2 Third Party Liability

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

The Plan does not cover benefits when some 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 covered expenses based on the 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 on behalf of the Plan or subrogation. Subrogation refers to substituting one party for another in a legal setting. We are entitled to all subrogation rights and remedies under common and statutory law, as well as under the Plan. You will cooperate 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 the 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 the Plan has paid whether the vision expenses are itemized or expressly excluded in the third party recovery.

c. If we, on behalf of the Plan, require you and your attorney to protect its recovery rights under this section, then you may subtract from the money to be paid back to the Plan a proportionate share of reasonable attorney fees as an expense for collecting from the other party.

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 7.3.2.

e. If it is reasonable to expect that you will have future expenses for which the Plan might pay benefits, , you will seek recovery of such future expenses in any third party claim.

f. Section 7.3.2 applies to you if the Plan advances benefits whether or not the event causing your injuries occurred before you became covered by Moda Health.

7.3.3 Motor Vehicle Accident Recovery

If you file a claim with us for vision expenses due to a motor vehicle accident and motor vehicle insurance has not yet paid, we, as administrator of the Plan, will advance benefits. We, on behalf of the Plan, have the right to be repaid from the proceeds of any settlement, judgement or other payment you receive that exceeds the amount that fully compensates you for your motor vehicle accident related vision injuries.

If we, on behalf of the Plan, require you or your attorney to protect our recovery rights under this section, then you may subtract from the money to be paid back to the Plan a proportionate share of reasonable attorney fees as an expense for collecting from the other party.

You will do whatever is required to secure, and may not prejudice, our rights under this section.

SECTION 8. CONTINUATION OF VISION COVERAGE

The Plan's continuation of coverage rules are outlined in the Oregon Administrative Rules under OAR 111-050-0001 through OAR 111-050-0080. Additional guidance on how to obtain continuation of coverage is outlined in the following sections.

8.1 RETIREES

The Plan's continuation rules for retirees are outlined in the Oregon Administrative Rules under OAR 111-050-0010 through 111-050-0050.

8.2 55+ OREGON CONTINUATION

55+ Oregon Continuation applies to employers with 20 or more employees. It provides 55+ continuation coverage for spouses and domestic partners age 55 and older who are not eligible for Medicare. If you lose coverage because the subscriber died or your marriage or domestic partnership with the subscriber ended, you may elect 55+ Oregon Continuation coverage for yourself and any enrolled dependents if you meet all the requirements.

You must notify the Group no more than 60 days after the date your marriage or domestic partnership is legally ended or within 30 days after the subscriber has died. Include your mailing address. You will be given information about how to sign up for continuation coverage and pay premiums. If you do not elect 55+ Continuation on time, you will lose the right to this continuation coverage.

Your coverage will end if you do not pay on time, or if the Plan as a whole ends. Otherwise 55+ Continuation ends when you become insured under any other group health plan that includes vision coverage, you become eligible for Medicare, or you remarry or register another domestic partnership.

If the Group or its third party administrator does not notify you of your continuation rights, the Group is responsible for premiums from the date the notice was required until the date you receive the notice.

8.3 COBRA CONTINUATION COVERAGE

The Plan's general COBRA rules are outlined in the Oregon Administrative Rules under OAR 111-050-0001.

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 the 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 the 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 met the definition of "child" under the 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 (such as divorce); and 4) the date the event occurred. You must give notice no later than 60 days after you lose coverage under the 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 the 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 the Plan as a result of the subscriber's termination or reduction of hours

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 150% of the premium. Your disability extension ends if you are no longer considered disabled.

If you are a spouse or child om 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 a subscriber, divorce or legal separation from the subscriber, or a child's no longer being eligible as a dependent under the 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.

Note: Longer continuation coverage may be available under Oregon law for a subscriber's spouse or domestic partner age 55 and older who loses coverage due to the subscriber's death, or due to legal separation or dissolution of marriage or domestic partnership (see section 8.2).

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 vision plan for 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 the 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**

References within the COBRA section to a spouse apply to a domestic partner unless otherwise stated. For divorce or legal separation, termination of domestic partnership applies for domestic partners.

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 the 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.

8.4 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 continued coverage under USERRA, or you cancel or use up your USERRA continuation, coverage restarts on the day you 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.

8.5 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 the 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.

8.6 LEAVE OF ABSENCE

A leave of absence is a period off work granted by the participating organization at a subscriber's request during which the subscriber is still considered to be employed and is carried on the employment records of the participating organization. A leave can be granted for any reason acceptable to the participating organization.

If granted a leave of absence by the participating organization, a subscriber may continue coverage based on OAR 111-050-0070. Premiums must be paid through OEBB in order to maintain coverage during a leave of absence.

8.7 STRIKE OR LOCKOUT

If employed under a collective bargaining agreement and involved in a work stoppage because of a strike or lockout, a subscriber may continue coverage for up to 6 months. You must pay the full premiums, including any part usually paid by the Group, to the union or trust The union or trust must send the premiums to us when due.

Continuation of coverage during a strike or lockout will not occur if:

a. Fewer than 75% of those normally enrolled choose to continue their coverage
b. You become employed full-time with another employer
c. You lose eligibility under the Plan

SECTION 9. DEFINITIONS

Terms used but not otherwise defined in this handbook shall have the same meaning as those terms in the OEBB Administrative Rules.

Claim Determination period means the plan year or portion thereof commencing October 1 of any calendar year and ending September 30 of the subsequent calendar year.

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

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

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

Enroll means to become covered for benefits under the 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 the Plan whether you elect coverage, you are a spouse, domestic partner or child 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 and supplies that meet one of the following:

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

In-Network refers to providers that are contracted under one of our approved networks to provide vision care to you.

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 vision services, supplies or interventions that a treating licensed vision care 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, supply or intervention is known to be effective in improving vision outcomes
c. The service, 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 or supplies (including court-ordered care) are medically necessity. No benefits will be paid if the proof is not received or is not acceptable, or if the service or supply is not medically necessary. Claims processing may be delayed if we require proof of medical necessity and it is not provided by the vision care provider.

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

See Treatment Not Medically Necessary in Exclusions (Section 4).

Member is a subscriber, spouse, eligible domestic partner or child. Where this book refers to "you" or "your" it is referring to a member.

Moda Health refers to Moda Health Plan, Inc.

Network is a group of vision providers who contract to provide vision care to you at negotiated rates. These groups are called Preferred Provider Organizations (PPOs), and provide in-network services in their specific service areas.

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

The **Plan** is the vision benefit plan sponsored by OEBB and offered through a minimum premium arrangement under the terms of the policy between OEBB 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 OEBB and Moda Health regarding the vision benefit plan sponsored by OEBB. This handbook is a part of the policy.

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

Subscriber is an eligible employee or former employee who is enrolled in the Plan.

Vision Provider is one of the following state-licensed or state-certified professionals, when providing medically necessary services or supplies within the scope of their license or certification

a. Hardware provider
b. Ophthalmologist
c. Optician
d. Optometrist

SECTION 10. GENERAL PROVISIONS & LEGAL NOTICES

10.1 GENERAL & MISCELLANEOUS PROVISIONS

Contract Provisions
The policy between Moda Health and OEBB 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 information. We use this information to pay your claims. 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 this 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.

Transfer of Benefits
Only members are entitled to benefits under the 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 vision provider. Our right to recovery includes the right to deduct the amount paid by mistake from future benefits we would provide for a member even if the mistaken payment was not made on that member's behalf.

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

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

No Waiver
Any waiver of any provision of the Plan or any performance under the 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 we or OEBB delay or fail to exercise any right, power or remedy provided in the Plan, including a delay or omission in denying a claim, that shall not waive Moda Health's or OEBB's rights to enforce the provisions of the Plan.

Group is the Agent
OEBB is the member's agent for all purposes under the Plan. OEBB is not the agent of Moda Health. Moda Health, as administrator of the Plan, is the representative of, and has authority to act for, OEBB under this handbook and the benefit plan document with Moda Health unless and until a member is otherwise notified in writing by OEBB. Where reference in this handbook is made to "the Plan" or to OEBB, such references shall include Moda Health acting in its capacity as administrator of the Plan.

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

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

Where any Legal Action Must be Filed
Any legal action arising out of the Plan must be filed in either state or federal court in the state of Oregon.

Time Limits for Filing a Lawsuit
Any legal action arising out of, or related to, the Plan and filed against Moda Health or OEBB by a member or any third party, must be filed in court no more than 3 years after the time the claim was filed (see section 7.1). All internal levels of appeal under the Plan must be exhausted before filing a legal action in court.

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

Notices
Any notice to you, to a provider or to the Group that we are required to provide is considered properly given if written notice is deposited in the 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.

Moda does not discriminate

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

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

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

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

888-217-2363 (TDD/TTY 711)

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

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

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

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

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

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

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

Dave Nesseler-Cass coordinates our nondiscrimination work:

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

moda HEALTH

DELTA DENTAL
Delta Dental of Oregon & Alaska

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

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

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

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

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

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

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

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

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

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

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

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

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

modahealth.com

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

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

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

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

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

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

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

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

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

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

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

moda HEALTH

DELTA DENTAL

Delta Dental of Oregon & Alaska

For help, call us directly at 866-923-0409.
(En español: 888-786-7461)

P.O. Box 40384
Portland, OR 97240