2023

Group Medical Plan

Public Employees Retirement System
Medicare Eligible Retired Members and their Dependents

Supplement Plan
Effective Date: January 1, 2023
Group Number: 10004761

PERS HEALTH INSURANCE PROGRAM
Public Employees Retirement System

Health Plans provided by Moda Health Plan, Inc.

STATE OF OREGON PUBLIC EMPLOYEES

RETIREMENT SYSTEM

GROUP INSURANCE PLAN

for

RETIRED MEMBERS AND THEIR DEPENDENTS

Underwritten By:

MODA HEALTH PLAN, INC.

Revised January 1, 2023

Policy No. 10004761

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SECTION 1. DISCLOSURES

The handbook is an important document describing the Medicare supplement plan sponsored by PERS and underwritten by Moda Health Plan, Inc. in detail. You should keep the handbook with your important papers. It describes benefits available beginning January 1, 2023 and replaces all previous handbooks.

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

1.1 NOTICE TO MEMBERS

The Plan may not cover all medical expenses.

1.2 MEMBER RESOURCES

Moda Health **Website** (log in to your Member Dashboard)
www.modahealth.com/pers

Medical Customer Service Department
Toll-free 800-962-1533
Llamado gratis 888-786-7461

Telecommunications Relay Service for the hearing impaired
711

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

We may monitor telephone conversations and e-mail communications you have with us. We will only do this when we determine there is a legitimate business purpose for doing so.

Note: 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.

SECTION 2. DEFINITIONS

Accident means accidental bodily injury sustained by you that is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and that occurs while insurance coverage is in force.

Approved Amount means the amount Medicare determines to be reasonable for a service that is covered under Medicare Part B. It may be less than the actual charge. For many services, including physician services, the approved amount is taken from a fee schedule that assigns a dollar value to all Medicare-covered services that are paid under that fee schedule.

Assignment means an arrangement in which a physician or medical supplier agrees to accept the Medicare-approved amount as full payment for services and supplies covered under Part B. Medicare usually pays 80% of the approved amount directly to the physician or supplier after the member meets the annual Part B deductible. You pay the other 20%.

Benefit Period is a way of measuring your use of hospital and skilled nursing facility services covered by Medicare. A benefit period begins the day you are hospitalized. It ends after you have been out of the hospital or other facility that primarily provides skilled nursing or rehabilitation services (or, if in the latter type of facility, has not received skilled care there) for 60 days in a row. If you are hospitalized after 60 days, a new benefit period begins, most Medicare Part A benefits are renewed, and you must pay a new inpatient hospital deductible. There is no limit to the number of benefit periods you can have.

Coinsurance is the portion or percentage of the Medicare approved amount that you are responsible for paying.

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

Dependent Domestic Partner means an individual who has a relationship with you that has the characteristics described below. You and your domestic partner must:

a. share a close personal relationship and be responsible for each other's common welfare, including but not limited to having joint financial responsibilities
b. be each other's sole domestic partner
c. not be married to anyone, nor have had another domestic partner within the previous 12 months
d. not be related by blood so closely as to bar marriage in the State of Oregon
e. have jointly shared the same regular and permanent residence for at least 12 months immediately preceding the effective date of coverage with the intent to continue doing so indefinitely
f. have the PERS retiree providing over one half of the financial support for the person and qualify as a dependent of the PERS retiree as determined under section 105(b) of the Internal Revenue Code, 26 USC 105(b), as amended by the Working Families Tax Relief Act of 2004, P.L. 108-311

The **Group** refers to Oregon Public Employees Retirement System (PERS).

Health care expenses means expenses associated with the delivery of health care to you.

Hospital means a Medicare approved institution that provides care for which Medicare pays hospital benefits.

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

Lifetime Reserve Days are a lifetime reserve of 60 days for Medicare Part A inpatient hospital care. These days must be used whenever more than 90 days of inpatient hospital care are needed in a benefit period.

Limiting Charge is the maximum amount a physician may charge a Medicare beneficiary for a covered physician service if the physician does not accept assignment of Medicare claims. The limit is 15% above the fee schedule amount for non-participating physicians. Limiting charge information appears on the Medicare Summary Notice (MSN).

Medicaid is a program established under Title XIX of The Social Security Disability Act to help some people with limited income and resources regarding their medical costs.

Medical Emergency means the sudden and unexpected onset of symptoms, illness, injury or condition that would be deemed, under appropriate medical standards, to carry substantial risk of serious medical complication or permanent damage to you if care or services are withheld.

Medicare is Parts A and B of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Medicare Eligible Expenses are expenses of the kind covered by Medicare to the extent recognized as reasonable and medically necessary by Medicare.

Medicare Part A Inpatient Hospital Deductible is the amount normally due from you upon first admission to a hospital in each benefit period, before benefits are available under Part A of Medicare.

Medicare Part B Deductible is the amount you must pay each calendar year before Part B of Medicare pays benefits for Medicare Part B expenses.

Medicare Part B Excess Charge is the amount for a service or supply that exceeds the Medicare approved amount. Physicians who do not accept assignment of a Medicare claim can charge you up to 15% more than the Medicare-approved amount. This is also referred to as a limiting charge.

Medicare Summary Notice (MSN) is a form Medicare sends to a beneficiary every three months showing all services and supplies billed to Medicare during the 3-month period, what Medicare paid, and what the beneficiary may owe the provider.

Member means any eligible person who is enrolled in the Plan. Where this handbook refers to "you" or "your" it is referring to a member.

Moda Health refers to Moda Health Plan, Inc. Where this handbook refers to "we", "us", or "our" it is referring to Moda Health or its employees.

PERS Health Insurance Program (PHIP) means the Program that offers group healthcare coverage to eligible retirees as well as their spouses and dependents who meet the eligibility requirements.

Physician means a licensed practitioner of the healing arts acting within the scope of the physician's license.

Plan means the Medicare supplement plan sponsored by the Group and insured under the terms of the policy between the Group and Moda Health.

Policy means the agreement between the Group and Moda Health for insuring the Medicare supplement plan sponsored by the Group. This handbook is a part of the policy

Premium means the periodic payment required from the Group in order for you to have coverage under the Plan.

Sickness means illness or disease that manifests itself after the effective date of insurance and while the insurance is in force.

Skilled Nursing Facility is a facility that provides skilled nursing care and is approved for payment by Medicare.

SECTION 3. SUMMARY OF BENEFITS

Medicare may, from time to time, change its deductible and copayment amounts. When this happens, the Plan will automatically cover the changed amounts that are eligible for benefits.

3.1 BENEFITS

a. The Medicare Part A hospital cost sharing amount for days 61 through 90 of hospitalization in each Medicare benefit period.

b. The Medicare Part A hospital cost sharing amount for each of Medicare's 60 non-renewable lifetime hospital inpatient reserve days.

c. 100% of the Medicare Part A eligible hospital expenses after all Medicare hospital benefits are exhausted. Coverage is limited to a maximum of 365 days of additional inpatient hospital care during your lifetime. This benefit is paid at the rate Medicare pays hospitalization under the applicable prospective payment system (PPS) or another appropriate Medicare standard of payment.

d. The first 3 pints of blood or equivalent quantities of packed red blood cells under both Medicare Part A and Part B per calendar year, unless replaced in accordance with federal regulations, and the coinsurance amount (20%) for additional pints of blood under Medicare Part B after Medicare Part B deductible is met.

e. The cost sharing amount of Medicare eligible expenses under Part B after the Medicare Part B deductible is met.

f. The Medicare Part A eligible hospice care and inpatient respite care cost sharing amount.

g. The Medicare Part A inpatient hospital deductible.

h. 100% of Medicare Part B excess charges, also known as limiting charges.

i. The skilled nursing facility care cost sharing amount for days 21 through 100 per benefit period.

j. Medically necessary emergency care in a foreign country is covered at 80%. This benefit is limited to a lifetime maximum of $50,000.

k. Outpatient mental health services are covered at 20% coinsurance after Medicare Part B deductible has been met.

Section 4 has additional details about the benefits under the Plan.

SECTION 4. BENEFIT DESCRIPTION

For covered stays and care, the Plan will pay as shown in Section 3. Section 4 describes the conditions under which benefits are payable for each type of coverage available under the Plan.

Medicare eligible expenses are covered under Parts A and B of Medicare. Part A provides coverage for stays in a hospital or in a skilled nursing facility. Part B covers medical care services and supplies.

Benefits may be paid for any covered charge that is a Medicare eligible expense subject to the same conditions and exclusions that apply under Medicare.

4.1 HOSPITAL CARE

When you are confined in a hospital, the benefit amounts as shown in Section 3 for a covered hospital stay will be paid if the following conditions are met:

a. The hospital stay begins on or after the effective date of the policy.
b. The hospital stay is covered under Part A of Medicare during a benefit period.
c. If past day 90 in any one benefit period, you are utilizing lifetime reserve days; or
d. If all Medicare hospital benefits are exhausted, the Plan will pay all Medicare Part A eligible expenses up to an additional 365 days of inpatient hospital care.

The service provider must accept the Plan's payment as payment in full and may not bill you for any balance.

4.2 MEDICAL CARE

For medical care eligible for payment under Medicare Part B, the benefits as shown in Section 3 will be paid if the following conditions are met:

a. Medicare Part B has paid a portion of the expenses when required by the Plan.
b. Medical care received as an inpatient occurred during a stay which began on or after the effective date of the policy. Medical care received as an outpatient must be received on or after the effective date of the policy.

4.3 SKILLED NURSING FACILITY STAYS

For skilled nursing facility stays, the Plan will pay the benefit amounts as shown in Section 3 Summary of Benefits for each covered confinement if the following conditions are met:

a. The skilled nursing facility stay is covered under Part A of Medicare during a benefit period.
b. The skilled nursing facility stay begins within 30 days after an inpatient hospital stay of 3 or more days in a row.

c. If admitted to a skilled nursing facility more than once in a benefit period, the confinement is for the same condition as the first stay in the benefit period.
d. Both the hospital and the skilled nursing facility stay must start while you are covered under the Plan.

4.4 EMERGENCY MEDICAL CARE IN FOREIGN COUNTRIES

For emergency medical care in foreign countries, the Plan will pay the benefit amounts as shown in Section 3 if the following conditions are met:

a. While on a trip outside the United States, you need emergency care. Emergency care means care needed immediately because of an injury or an illness of sudden or unexpected onset.
b. The emergency hospital, physician or medical care received in the foreign country would have been covered by Medicare if provided in the United States.
c. The emergency medical care is not eligible for payment under any Medicare program.
d. The emergency medical care lifetime maximum of $50,000 has not been reached.
e. The emergency medical care is received on or after the effective date of the policy.

Benefits for emergency medical care in a foreign country are payable only to you in United States currency in an amount based on the bank transfer exchange rate in effect on the day the claim payment is processed in the United States.

4.5 AMBULANCE TRANSPORTATION

Ambulance transportation, including local ground transportation by state certified ambulance and certified air ambulance transportation, is covered for medically necessary transport to the nearest facility that has the capability to provide the necessary treatment.

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

4.6 HEARING SERVICES BENEFIT

The Plan covers routine hearing aid examinations and hearing aids. You must see a TruHearing provider to receive this benefit. You can call 1-833-718-5798 to choose an in-network audiologist or hearing instrument specialist and arrange for a hearing exam. The TruHearing audiologist or hearing instrument specialist will assist you with choices of hearing aids. The TruHearing hearing services network has a selection of hearing aids available.

The following expenses are covered:

a. One hearing exam and evaluation per year by a TruHearing provider
b. One TruHearing-branded Advanced or Premium hearing aid per ear per year
c. One year of provider visits after the hearing aid purchase
d. 60-day trial period
e. 3-year extended warranty
f. 80 batteries per hearing aid for non-rechargeable models (you would not need batteries for rechargeable hearing aids)
g. Rechargeable battery option is available on select styles at no additional cost

Services	Cost Sharing	Details
Hearing aid exam	$0 copayment	One per year
Hearing aids	$399 copayment per aid for TruHearing Advanced Hearing Aids $699 copayment per aid for TruHearing Premium Hearing Aids	Two TruHearing Advanced or Premium hearing aids every year (one per ear)

The following services and supplies are not covered:

a. Ear molds
b. Hearing aid accessories
c. Additional provider visits
d. Extra batteries
e. Hearing aids that are not TruHearing Advanced or TruHearing Premium hearing aids obtained through TruHearing
f. Costs associated with loss and damage warranty claims

4.7 VISION SERVICES BENEFIT

The Plan covers vision exams and corrective lenses and frames. Vision Services Plan (VSP) will provide benefit authorization directly to a provider in the VSP Advantage network. To locate a VSP Advantage doctor, please visit vsp.com/advantageonly. When contacting a VSP Advantage network provider directly, you must identify yourself as a VSP member and the provider will obtain benefit authorization from VSP. Should you obtain services from a provider who is not in the VSP Advantage network, you are responsible for payment in full to the provider and will need to submit a request for reimbursement by completing the VSP Member Reimbursement Form. For information on how to submit a claim to VSP for reimbursement, visit www.vsp.com or call 800-877-7195. Payment in these instances is limited to the out-of-network provider reimbursement rate.

The following expenses are covered:

a. One routine vision exam per calendar year. There is a $15 copayment when using a VSP Advantage network provider. Reimbursement is limited to up to $45 of the cost of the exam when using an out-of-network provider.
b. $200 every 2 calendar years for lenses, lens enhancements and frames through a VSP Advantage network provider. A 20% discount is applied before the $200 allowance when using a VSP Advantage network provider. When using an out-of-network provider, reimbursement is limited to $200 for the cost of lens, lens enhancements, or frame.
c. Or, $200 allowance for contacts and contact lens exam (instead of lenses and frame) when using a VSP Advantage network provider. A 15% discount is applied off the contact lens exam before the $200 allowance when using a VSP Advantage network provider. When using an out-of-network provider, reimbursement is limited to $200 for the cost of contacts and contact lens exam.

Services	**Cost Sharing**
Well Vision Exam – One exam per calendar year	<u>VSP Advantage network</u> $15 copayment <u>Out-of-network</u> Up to $45 reimbursement of the exam cost.
Lenses, Lens Enhancements, Frame	<u>VSP Advantage network</u> Up to $200 allowance every 2 calendar years. A 20% discount is applied prior to the allowance. <u>Out-of-network</u> Up to $200 reimbursement every 2 calendar years.
Contacts – Contacts and contact lens exam (fitting and evaluation)	<u>VSP Advantage network</u> Up to $200 allowance every 2 calendar years. A 15% discount off the contact lens exam is applied prior to the allowance. <u>Out-of-network</u> Up to $200 reimbursement every 2 calendar years.

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. Replacement of lenses, frame, or contacts
d. Medical or surgical treatment
e. Orthoptics
f. Vision training or supplemental testing

The following additional services and supplies are not covered under the contact lens coverage:

a. Insurance policies or service agreements
b. Artistically painted or non-prescription lenses
c. Additional office visits for contact lens pathology
d. Contact lens modification
e. Polishing or cleaning

SECTION 5. VALUE-ADDED SERVICES AND DISCOUNTS

With enrollment to this Moda Health Medicare Supplement plan, you have access to additional services, programs and tools to support your physical, mental and emotional health. When you use these programs, you may receive savings on an item or service that is covered by the Plan. Access these extras through your Member Dashboard.

These additional services are a complement to the Moda Health Medicare Supplement plan, but are not insurance.

5.1 WELLNESS PRODUCTS AND SERVICES

Members have access to the following health and wellness services through ChooseHealthy:

a. Discounts on popular health and fitness brands
b. Saving on services from specialty health practitioners including acupuncture, chiropractic and therapeutic massage
c. Access to no-cost online health classes

The ChooseHealthy program is available to members who are able to access the program through their Member Dashboard at www.modahealth.com/pers or call Customer Service at 877-335-2746.

5.2 FITNESS CENTER MEMBERSHIP THROUGH SILVER&FIT

The Silver&Fit program offers memberships at a fitness center or fitness studio, including:

a. Access to over 15,000 fitness studios and fitness centers nationwide
b. One home fitness kit per calendar year which includes options such as a wearable fitness tracker kit, a Yoga kit or a strength kit
c. A premium network option that includes access to additional fitness studios, including Yoga and Pilates for an additional fee through the Silver&Fit program
d. Access to on-demand workout videos, including daily classes on the Silver&Fit Facebook and YouTube page
e. Healthy Aging Classes available on DVD and on the silverandfit.com website
f. The Well-Being Club for member connection, exclusive articles and videos, and live-streaming classes and events

To enroll and get more information, contact Silver&Fit Customer Service at 877-427-4788. Find participating gyms online at silverandfit.com.

5.3 TRAVEL ASSISTANCE SERVICES

Travel assistance services are provided through Assist America and are available when members are traveling more than 100 miles away from home and experiencing a medical or non-medical emergency. These services include, but are not limited to:

a. Foreign hospital admission assistance
b. Emergency medical evacuation
c. Arrangements for the member to be transported home or to a rehabilitation facility upon being discharged from the hospital
d. Lost luggage and document assistance
e. Interpreter and legal referral

To activate these services, you can call Assist America at 800-872-1414, or reach Assist America by email at medservices@assistamerica.com.

5.4 REGISTERED NURSE ADVICE LINE

You can use the toll-free Registered Nurse Advice Line to speak with a registered nurse. The Registered Nurse Advice Line phone number is listed in your Member Dashboard and is available at no additional cost.

By calling the Registered Nurse Advice Line, you can:

a. Access a registered nurse, 24 hours a day, 365 days a year
b. Receive answers and advice about non-critical medical issues

SECTION 6. GENERAL EXCLUSIONS

At-Home Recovery Care
No benefits are available for short term, at-home assistance provided by a home health aide, homemaker, personal care aide, or nurse for activities of daily living. Activities of daily living include but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

Care Provided Without Charge
No benefits are provided for stays, care, or visits for which no charge would be made to you in the absence of insurance.

Deductibles
No benefits are available for the Medicare Part B deductible.

Duplicate Benefits
In no event will medical payment under the Plan duplicate any amounts payable under Medicare.

Government Hospitals
The Plan will not cover a stay, service, supply, or facility provided by a hospital or other institution owned or operated by a national government or any other government, unless payment of the charge is required by law.

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

Outpatient Prescription Drugs
No benefits are provided for outpatient prescription drugs, except outpatient drugs covered by Medicare Part A for hospice care.

Preventive Medical Care
Only preventive services covered under Medicare Part B are eligible for benefits.

Recalled Surgically Implanted Devices
Moda Health is not liable for illness or injuries due to recalled surgically implanted devices or to complications of surgically implanted devices covered by manufacturer warranty.

Services Not Covered by Medicare
No benefits are provided for charges that are not covered expenses under your Medicare plan, unless otherwise specifically stated in this handbook.

Taxes
Taxes and fees that are charged in addition to the services provided.

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

SECTION 7. ELIGIBILITY

7.1 WHO IS ELIGIBLE FOR COVERAGE

A person is eligible to enroll in the Plan if the person is enrolled in Medicare Parts A and B and:

a. is a PERS retiree and/or spouse, dependent or dependent domestic partner of a PERS retiree; or
b. is an eligible surviving spouse, dependent or dependent domestic partner of a deceased PERS retiree; or
c. is an eligible surviving spouse, dependent or dependent domestic partner of a deceased PERS member who was not retired but who was eligible to retire at the time of death

7.2 DEPENDENT CHILD

A retiree's Medicare eligible children are eligible on the Plan until their 26th birthday. The child may be legally adopted or placed in the home pending adoption. Legal custody or guardianship does not apply.

A retiree's child who has sustained a disability rendering the child physically or mentally incapable of self-support at even a sedentary level, may be eligible for coverage even though the child is over 26 years old. To be eligible, the child must:

a. be unmarried,
b. be principally dependent since childhood on the retiree for support or
c. have been covered under a healthcare insurance plan as the retiree's dependent for at least 24 consecutive months immediately prior to enrollment in the Plan and
d. have had continuous medical coverage.

The incapacity must have started, and the information below must be received, before the child's 26th birthday. Social Security Disability status does not guarantee coverage under this provision. Moda Health will determine eligibility based on commonly accepted guidelines. To avoid a break in coverage, it is recommended that the following information be submitted to Moda Health at least 45 days before the child's 26th birthday:

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

SECTION 8. ENROLLMENT

The following enrollment times are the only enrollment opportunities offered. Eligible persons who do not enroll during one of these enrollment periods will lose the opportunity to enroll in the Plan.

8.1 ENROLLING ELIGIBLE PERSONS

8.1.1 New Retiree

New retirees and their eligible spouses, dependent domestic partners or dependent children may enroll by completing an enrollment request form and submitting it to PHIP within 90 days of the effective date of their PERS retirement, within 90 days of the date of the Notice of Award letter issued by the Social Security Administration or within 90 days of the date of the Disability Approval Letter for a person who receives retroactive eligibility for disability retirement. Coverage will begin on the PERS retirement effective date if applying before the retirement date or on the first day of the month following receipt of the completed enrollment request form if applying after the retirement date.

8.1.2 Medicare Eligibility

Retirees or their eligible spouses, dependent domestic partners or dependent children may enroll by filling out an enrollment request form and submitting it to PHIP within 90 days of the date of initial Medicare eligibility if enrolled in both Part A and Part B. For a person who receives retroactive eligibility for Medicare as a result of an appeal to an initial denial for eligibility, the enrollment form must be submitted within 90 days from the date the person is notified of their enrollment in Medicare. Coverage will begin on the date Medicare coverage becomes effective if applying before the date of Medicare eligibility and on the first day of the month following receipt of the enrollment form if applying after the date of Medicare eligibility.

8.1.3 Continuous Group Coverage

Retirees may enroll by filling out an enrollment request form and submitting it to PHIP within 30 days of the loss of other coverage if they have been covered under another group health plan for 24 consecutive months immediately preceding enrollment in the Plan. Coverage will begin on the date the other coverage ends.

An eligible spouse, dependent domestic partner, or dependent child must be enrolled at the same time as the retiree. A new spouse, dependent domestic partner, or dependent child who is eligible must enroll within 30 days of becoming a spouse, dependent domestic partner or dependent child.

8.2 TERMINATION

Coverage under the Plan will end on the date that the first of the following events happens:

a. The date the Plan terminates
b. The premium due date when PHIP fails to pay the required premium
c. The last day of the period for which you have made the required premium contribution

d. The date you no longer meet the eligibility requirements of the Plan
e. The first day of the month following your written notice of termination of coverage

If coverage is terminated for nonpayment of premium, coverage may be reinstated for good cause following Medicare and PHIP guidelines.

8.3 SUBSCRIBER'S DEATH

a. An eligible surviving spouse, dependent domestic partner or dependent child who is enrolled in the Plan may continue coverage under that plan according to OAR 459-035-0070 (1)(d).
b. An eligible surviving spouse, dependent domestic partner or dependent child who is not covered at the time of the subscriber's death may enroll according to OAR 459-035-0070 (1)(e)

    i. within 90 days of the death
    ii. within 30 days of the loss of other group coverage that was in effect for 24 consecutive months immediately preceding enrollment
    iii. within 90 days of initial Medicare eligibility, if enrolled in Parts A and B of Medicare

8.4 RESCISSION BY INSURER

Recission means canceling (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 nonpayment of premium or a material misrepresentation that is discovered within two years after the effective date of your coverage. Examples of 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
c. Submitting false or altered claims

We have the right to keep any premiums paid as liquidated damages. You will have to repay any benefits that have been paid. If we end coverage under this section, we may, to the extent permitted by law, deny future enrollment of members under any Moda Health Plan, Inc. policy or contract or the contract of any affiliates.

8.5 BENEFITS AFTER COVERAGE STOPS

If the Plan is terminated, coverage ends on the date the Plan ends. However, if you are in the hospital on the day the policy ends, the Plan will continue to pay toward covered expenses for that hospitalization until discharge from the hospital or benefits are exhausted, whichever comes first. This is the only situation in which the Plan will pay toward an expense incurred while you are not covered.

SECTION 9. CLAIMS ADMINISTRATION AND PAYMENT

9.1 CLAIM FILING

Before the Plan can pay any benefits, the provider of service must file a claim for those expenses with Medicare. We must receive notification from the Medicare carrier of its payment. Only those charges determined by Medicare to be Medicare eligible expenses will be covered under the Plan.

If you live in Oregon, call Customer Service to arrange to have your Medicare claims sent to us electronically. You may then submit your claims to Medicare, and we will automatically be notified of what was paid.

If you live outside of Oregon, you will need to send claims, along with the Medicare Explanation of Benefits, to us.

In no event, except absence of legal capacity or in the case of a Medicaid claim, is a claim valid if submitted later than 12 months from the expense was incurred. Claims submitted by Medicaid must be sent to Moda Health within 3 years after the date the expense was incurred.

9.1.1 Out-of-Country Foreign Claims

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

a. Patient's name, member's name, and group and identification numbers
b. Statement explaining where the member was and why they sought care
c. Copy of the medical record (translated is preferred if available)
d. Itemized bill for each date of service
e. Proof of payment in the form of a credit card/bank statement or cancelled check

9.2 PAYMENT OF CLAIM

Benefits payable under the Plan will be paid to whoever received the Medicare benefits. Foreign travel emergency care benefits will be payable directly to you.

9.2.1 Explanation of Benefits (EOB)

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

If 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.

9.2.2 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. The phone numbers are found in section 1.2.

9.3 LEGAL ACTIONS

You cannot bring any action at law or in equity for any benefits under the Plan until 60 days after filing a claim. No such action can be brought once 3 years have passed from the date the claim was required to have been filed.

9.4 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 Customer Service for more information.

The 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 the Plan will pay your covered expenses based on the understanding and agreement that the Plan is 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 the Plan's right of recovery or subrogation. Subrogation refers to substituting one party for another in a legal setting. The Plan is entitled to all subrogation rights and remedies under the common and statutory law, as well as under the Plan. You will cooperate with us to protect the Plan's subrogation and recovery rights. This includes signing and delivering any documents we reasonably require to protect the Plan's rights and providing any information or taking actions that will help us recover costs from a third party Moda Health has the option to interpret and construe these recovery and subrogation provisions.

a. If the Plan pays 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 the Plan.

b. The Plan is 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. The Plan is entitled to receive the amount of benefits the Plan has paid whether the healthcare expenses are itemized or expressly excluded in the third party recovery.

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

d. 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 9.4.

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 9.4 applies to you if the Plan advances benefits whether or not the event causing your injuries occurred before you became covered by the Plan.

g. If you or your representatives do not comply with the requirements of this section, then the Plan may not advance payment or may suspend payment of any benefits, or recover any benefits hawse have advanced, for any medical condition related to the third party claim except for claims related to motor vehicle accidents (see section 9.4.1). We may notify medical providers seeking payment that all payments have been suspended or may not be paid.

9.4.1 Motor Vehicle Accident Recovery

If you file a claim with us for healthcare expenses due to a motor vehicle accident and motor vehicle insurance has not yet paid, then the Plan will advance benefits. The Plan retains the right to be paid 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 injuries.

If the Plan requires you or 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.

You will do whatever is required to secure, and may not prejudice, the rights of Moda Health under this section.

SECTION 10. CLAIMS ADMINISTRATION AND PAYMENT

10.1 When Medicare is Secondary

We coordinate benefits with Medicare as required under federal law. When Medicare becomes a secondary payer because of benefits from other plans, such as another Medigap plan with another carrier, or coverage, benefits payable under the Plan will be paid as if Medicare's normal benefits had not been reduced. The Plan may reduce its benefits so that the total benefits paid by all plans are not more than the total allowable expense.

10.2 Non-Duplication of Benefits

Services are eligible for only one type of benefit under the Plan. For example, if a service is defined as skilled nursing facility care, it is reimbursed under that benefit only.

10.3 Effect of Change of Plan

If on the effective date you have changed to the Plan from any other Moda Health supplement plan, no benefits will be paid under the Plan for any stay or care to the extent that benefits are paid under the prior plan.

10.4 Medicaid

Benefits and premiums under the Plan will be suspended during your entitlement to benefits under Medicaid for up to 24 months. This suspension must be requested within 90 days of becoming eligible for Medicaid. If no longer entitled to Medicaid, coverage will be reinstated if you make a request for reinstatement within 90 days of the date you are no longer entitled to Medicaid. Coverage may be reinstated as of the date Medicaid entitlement is lost if premiums due for that period are paid.

10.5 Recovery of Benefits Paid by Mistake

If the Plan 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, the Plan has the right to recover the payment from the person paid or anyone else who benefited from it, including a physician or provider of services. The Plan's right to recovery includes the right to deduct the amount paid from future benefits it would provide for a member even if the mistaken payment was not made on that member's behalf.

10.6 CONFIDENTIALITY OF MEMBER INFORMATION

Keeping your protected health information (PHI) is very important to the Plan. PHI includes enrollment, claims, and medical and dental information. This information is used 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. A copy of the notice is available on our website by following the HIPAA link or by calling 855-425-4192.

Nondiscrimination notice

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

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

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

If you need any of the above, call the following numbers (depending on the coverage you have):

Medicare Customer Service,
800-962-1533

Pharmacy Customer Service,
888-786-7509

Dental Customer Service,
844-827-7379

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

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

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

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.

Moda Health Plan, Inc. is a PPO and PDP with Medicare contracts. Enrollment in Moda Health Plan, Inc. depends on contract renewal. 1604 (07/21)

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 888-786-7509 (TTY: 711).

CHÚ Ý: Nếu bạn nói tiếng Việt, có dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Gọi 888-786-7509 (TTY:711)

注意：如果您說中文，可得到免費語言幫助服務。請致電888-786-7509（聾啞人專用：711）

주의: 한국어로 무료 언어 지원 서비스를 이용하시려면 다음 연락처로 연락해주시기 바랍니다. 전화 888-786-7509 (TTY: 711)

PAUNAWA: Kung nagsasalita ka ng Tagalog, ang mga serbisyong tulong sa wika, ay walang bayad, at magagamit mo. Tumawag sa numerong 888-786-7509 (TTY: 711)

تنبيه: إذا كنت تتحدث العربية، فهناك خدمات مساعدة لغوية متاحة لك مجانًا. اتصل برقم 888-786-7509 (الهاتف النصي: 711)

توجہ دیں: اگر آپ اردو (URDU) بولتے ہیں تو آپ کے لیے بلا معاوضہ دستیاب لسانی اعانت 888-786-7509 (TTY: 711) پر کال کریں ۔ہے

ВНИМАНИЕ! Если Вы говорите по-русски, воспользуйтесь бесплатной языковой поддержкой. Позвоните по тел. 888-786-7509 (текстовый телефон: 711).

ATTENTION : si vous êtes locuteurs francophones, le service d'assistance linguistique gratuit est disponible. Appelez au 888-786-7509 (TTY : 711)

توجه: در صورتی که به فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما موجود است. با 888-786-7509 (TTY: 711) تماس بگیرید.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपको भाषाई सहायता बिना कोई पैसा दिए उपलब्ध है। 888-786-7509 पर कॉल करें (TTY: 711)

Achtung: Falls Sie Deutsch sprechen, stehen Ihnen kostenlos Sprachassistenzdienste zur Verfügung. Rufen sie 888-786-7509 (TTY: 711)

注意：日本語をご希望の方には、日本語サービスを無料で提供しております。888-786-7509（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/pers

અગત્યનું: જો તમે (ભાષાંતર કરેલ ભાષા અહીં દર્શાવો) બોલો છો તો તે ભાષામાં તમારે માટે વિના મૂલ્યે સહાય ઉપલબ્ધ છે. 888-786-7509 (TTY: 711) પર કૉલ કરો

ໂປດຊາບ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການຊ່ວຍເຫຼືອດ້ານພາສາແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ເສັຽຄ່າ. ໂທ 888-786-7509 (TTY: 711)

УВАГА! Якщо ви говорите українською, для вас доступні безкоштовні консультації рідною мовою. Зателефонуйте 888-786-7509 (TTY: 711)

ATENŢIE: Dacă vorbiţi limba română, vă punem la dispoziţie serviciul de asistenţă lingvistică în mod gratuit. Sunaţi la 888-786-7509 (TTY 711)

THOV CEEB TOOM: Yog hais tias koj hais lus Hmoob, muaj cov kev pab cuam txhais lus, pub dawb rau koj. Hu rau 888-786-7509 (TTY: 711)

ត្រូវចងចាំ៖ បើអ្នកនិយាយភាសាខ្មែរ ហើយ ត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដោយ ឥតគិតថ្លៃ គឺមានផ្តល់ជូនលោកអ្នក។ សូមទូរស័ព្ទ ទៅកាន់លេខ 888-786-7509 (TTY: 711)

HUBACHIISA: Yoo afaan Kshtik kan dubbattan ta'e tajaajiloonni gargaarsaa isiniif jira 888-786-7509 (TTY:711) tiin bilbilaa.

โปรดทราบ: หากคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี โทร 888-786-7509 (TTY: 711)

FA'AUTAGIA: Afai e te tautala i le gagana Samoa, o loo avanoa fesoasoani tau gagana mo oe e le totogia. Vala'au i le 888-786-7509 (TTY: 711)

IPANGAG: Nu agsasaoka iti Ilocano, sidadaan ti tulong iti lengguahe para kenka nga awan bayadna. Umawag iti 888-786-7509 (TTY: 711)

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń: 888-786-7509 (obsługa TTY: 711)

moda HEALTH

DELTA DENTAL

Delta Dental of Oregon & Alaska

For help, call us directly at 800-962-1533
(En Español: 888-786-7461)

P.O. Box 40384
Portland, OR 97240

ModaORLGbk 1-1-2023 (10004761)