2027

Group Medical Plan

Public Employees Retirement System
Medicare Eligible Retired Members and their Dependents

Supplement Plan
Effective Date: January 1, 2027
Group Number: 10004761

PERS HEALTH INSURANCE PROGRAM
Public Employees Retirement System

Health Plans provided by Moda Health Plan, Inc.

ModaORLGbk 1-1-2026 / 10004761

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, 2027

Policy No. 10004761

TABLE OF CONTENTS

SECTION 1. DISCLOSURES 1

1.1 NOTICE TO MEMBERS 1
1.2 MEMBER RESOURCES 1

SECTION 2. DEFINITIONS 2

SECTION 3. SUMMARY OF BENEFITS 5

3.1 BENEFITS 5

SECTION 4. BENEFIT DESCRIPTION 6

4.1 HOSPITAL CARE 6
4.2 MEDICAL CARE 6
4.3 SKILLED NURSING FACILITY STAYS 6
4.4 EMERGENCY MEDICAL CARE IN FOREIGN COUNTRIES 7
4.5 AMBULANCE TRANSPORTATION 7
4.6 HEARING SERVICES BENEFIT 7
4.7 VISION SERVICES BENEFIT 8

SECTION 5. VALUE-ADDED SERVICES AND DISCOUNTS 10

5.1 WELLNESS PRODUCTS AND SERVICES 10
5.2 FITNESS CENTER MEMBERSHIP THROUGH ONE PASS® 10
5.3 TRAVEL ASSISTANCE SERVICES 11
5.4 REGISTERED NURSE ADVICE LINE 11

SECTION 6. GENERAL EXCLUSIONS 12

SECTION 7. ELIGIBILITY 14

7.1 WHO IS ELIGIBLE FOR COVERAGE 14
7.2 DEPENDENT CHILD 14

SECTION 8. ENROLLMENT 15

8.1 ENROLLING ELIGIBLE PERSONS 15
8.1.1 New Retiree 15
8.1.2 Medicare Eligibility 15
8.1.3 Continuous Group Coverage 15
8.2 TERMINATION 16
8.3 SUBSCRIBER'S DEATH 16
8.4 RESCISSION BY INSURER 16
8.5 BENEFITS AFTER COVERAGE STOPS 17

SECTION 9. CLAIMS ADMINISTRATION AND PAYMENT 18

9.1 CLAIM FILING 18
9.1.1 Out-of-Country Foreign Claims 18
9.2 PAYMENT OF CLAIM 18
9.2.1 Explanation of Benefits (EOB) 18
9.2.2 Claim Inquiries 19
9.3 LEGAL ACTIONS 19

9.4 THIRD-PARTY LIABILITY 19
9.4.1 Motor Vehicle Accident Recovery 20
SECTION 10. CLAIMS ADMINISTRATION AND PAYMENT 21
10.1 WHEN MEDICARE IS SECONDARY 21
10.2 NON-DUPLICATION OF BENEFITS 21
10.3 EFFECT OF CHANGE OF PLAN 21
10.4 RECOVERY OF BENEFITS PAID BY MISTAKE 21
10.5 CONFIDENTIALITY OF MEMBER INFORMATION 22
SECTION 11. NONDISCRIMINATION 23

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, 2027 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 call TruHearing to schedule an appointment with a TruHearing provider to receive this benefit. You can call TruHearing at 1-833-718-5797 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. TruHearing has a selection of hearing aids available in various styles and colors.

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. The first year (12 months) of TruHearing 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 (except as specifically described in the covered benefits)
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

Costs associated with excluded items are the responsibility of the member and not covered by the plan.

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 www.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 to any overages after 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) every 2 calendar years 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	VSP Advantage network $15 copayment Out-of-network Up to $45 reimbursement of the exam cost.
Lenses, Lens Enhancements, Frame	VSP Advantage network Up to $200 allowance every 2 calendar years. A 20% discount is applied to any overages after the $200 allowance. Out-of-network Up to $200 reimbursement every 2 calendar years.
Contacts Contacts and contact lens exam (fitting and evaluation)	VSP Advantage network Up to $200 allowance every 2 calendar years. A 15% discount off the contact lens exam is applied prior to the allowance. Out-of-network 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

Moda Wellness Clinic:
Show your member ID card to get a 10% discount on aesthetic services, IV therapy and products at the Moda Wellness Clinic.

Call Moda Wellness Clinic at 503-206-6200 if you have questions or to schedule an appointment. Moda Wellness Clinic, LLC is a company in the Moda Partners, Inc. family of companies. They provide functional care, nutrition support and aesthetic services to the public. This discount cannot be used with other promotions or discounts.

Products and Services:
You 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 ONE PASS®

Members may access the One Pass program that supports a variety of fitness and wellness resources at no additional cost.
One Pass includes:

a. Access to the largest nationwide network of gyms and fitness locations
b. Live, digital fitness classes and on-demand workouts
c. Online brain training made just for you to help improve your memory and focus
d. Groups, clubs and social events near you so that you can meet like-minded people
e. Meal delivery services to make healthy eating easy

To learn more or enroll, visit YourOnePass.com or call 877-504-6830.

One Pass is offered through Rally Health, Inc., a subsidiary of UnitedHealth Group. Participation and services may vary by location and are subject to change.

5.3 TRAVEL ASSISTANCE SERVICES

You have access to some travel assistance services through Assist America. These services include, but are not limited to:

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

These travel assistance services are automatically available when you enroll in this plan. You do not have to accept or decline the services. Also, there is no additional cost for you to use the services.

You can use the services while traveling more than 100 miles from your permanent home or outside of the United States. Services will not be provided for trips exceeding 90 days from your legal residence.

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

You are eligible to enroll in the Plan if you are enrolled in Medicare Parts A and B and:

a. are a PERS retiree and/or spouse, dependent or dependent domestic partner of a PERS retiree; or
b. are an eligible surviving spouse, dependent or dependent domestic partner of a deceased PERS retiree; or
c. are 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.

Your 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 you for support or
c. have been covered under a healthcare insurance plan as your 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. If you are eligible and you do not enroll during one of these enrollment periods, you will lose the opportunity to enroll in the Plan.

8.1 ENROLLING ELIGIBLE PERSONS

8.1.1 New Retiree

If you are a new retiree, you and your eligible spouse, dependent domestic partner or dependent children may enroll by completing an enrollment request form and submitting it to PHIP within 90 days of the effective date of your 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, if you receive 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

You 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. If you receive 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 you are notified of your 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.

An eligible spouse may enroll prior to you at their initial Medicare eligibility; otherwise they must be enrolled at the same time as you.

An eligible dependent domestic partner, or dependent child must be enrolled at the same time as you.

8.1.3 Continuous Group Coverage

You may enroll by filling out an enrollment request form and submitting it to PHIP within 30 days of the loss of other coverage if you 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 you. 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 you fail to pay the required premium
c. The date you no longer meet the eligibility requirements of the Plan
d. 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 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.

10.5 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

PERS HEALTH INSURANCE PROGRAM
Public Employees Retirement System

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

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

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

If you need any of the above, call:

Medicare Customer Service,
800-962-1533 (TDD/TTY 711)

Pharmacy Customer Service,
888-786-7509 (TDD/TTY 711)

Dental Customer Service,
844-827-7379 (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 Health Plan, 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.

Scott White coordinates our nondiscrimination work:

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

modahealth.com/pers

Moda Health Plan, Inc. is a PPO and PDP with Medicare contracts. Enrollment in Moda Health Plan, Inc. depends on contract renewal.

moda HEALTH

DELTA DENTAL

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

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

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

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

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

注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適　な補助支援やサービスも無料でご利用いただけます。1-877-605-3229 (TTY: 711) までお電話ください。または、ご利用の事業者にご相談ください。

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

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

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

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

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

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

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

ຊືນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ,
ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ.
ມີເຄື່ອງຊ່ວຍ ແລະ
ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-877-605-3229 (TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

หมายเหตุ: หากคุณใช้ภาษา ไทย
เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้
ยังมีเครื่องมือและบริการช่วยเหลือเฟื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ 1-877-605-3229 (TTY: 711) หรือปรึกษาผู้ให้บริการของคุณ

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

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

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

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

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

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-877-605-3229 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

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

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

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

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

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



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

P.O. Box 40384
Portland, OR 97240