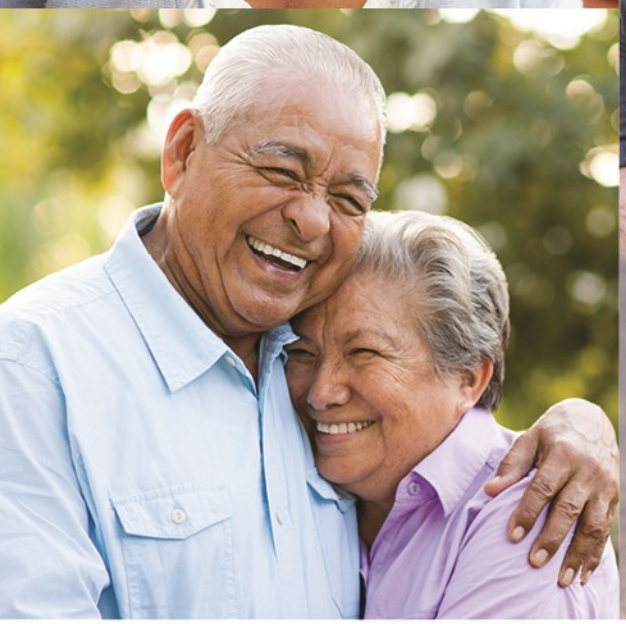

Group Medical Plan

PERS HEALTH INSURANCE PROGRAM
Public Employees Retirement System

Public Employees Retirement System
Medicare Eligible Retired Members and their Dependents

Supplement Plan
Effective Date: January 1, 2020
Group Number: 10004761

Health plans in Oregon by Moda Health Plan, Inc.

moda HEALTH

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, 2020

Policy No. 10004761

ADDITIONAL MEMBERSHIP ADVANTAGES

With enrollment to this PERS Moda Health Medicare supplement plan, members are provided with additional services and value added discounts including the following:

- Discounts on eye exams, frames, lenses and contacts through the VSP Access discount program when seeing a VSP provider
- Discounts on massage therapy, chiropractic and acupuncture through the ChooseHealthy Program
- Membership at a participating fitness center or two home fitness kits per year through the Silver&Fit Program

THESE ADDITIONAL SERVICES ARE A COMPLEMENT TO THE PERS MODA HEALTH MEDICARE SUPPLEMENT PLAN, BUT ARE NOT INSURANCE.

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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, and should be kept with members' other important papers. It describes benefits available beginning January 1, 2020 and replaces all previous handbooks.

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

Medical Customer Service Department
Portland 503-243-3880; Toll-free 800-962-1533
En Español 503-265-2961; Llamado gratis 888-786-7461

Telecommunications Relay Service for the hearing impaired
711

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

Moda Health reserves the right to monitor telephone conversations and e-mail communications between its employees and its customers for legitimate business purposes as determined by Moda Health.

Note: This handbook may be changed or replaced at any time, by the Group or Moda Health, without the consent of any member. The most current handbook is available on Member Dashboard, accessed through the Moda Health website. 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 the member 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. The member pays the other 20%.

Benefit Period is a way of measuring a member's use of hospital and skilled nursing facility services covered by Medicare. A benefit period begins the day the member is hospitalized. It ends after the member has 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 the member is hospitalized after 60 days, a new benefit period begins, most Medicare Part A benefits are renewed, and the member must pay a new inpatient hospital deductible. There is no limit to the number of benefit periods a member can have.

Coinsurance is the portion or percentage of the Medicare approved amount that a member is responsible for paying.

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

Dependent Domestic Partner means an individual who has a relationship with the member that has the characteristics described below. The member and dependent 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 the member.

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 the member 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 a member 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 a member 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 a member up to 15% more than the Medicare-approved amount. The Medicare approved amount is also called the 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.

Moda Health refers to Moda Health Plan, Inc.

Physician means a licensed practitioner of the healing arts acting within the scope of his or her 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 the member to have coverage under the Plan.

Sickness means illness or disease of the member 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 the member's 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.

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

For members 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, the member is 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 the member 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 the member is 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, the member needs 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 the member 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. Members must see a TruHearing provider to receive this benefit. Members can call 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 members with choices of hearing aids. The TruHearing hearing services network has a selection of hearing aids available to members.

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. Three provider visits within the first year of the hearing aid purchase
d. 45-day trial period

e. 3 year extended warranty
f. 48 batteries per hearing aid on rechargeable models

Services	Cost Sharing	Details
Hearing aid exam	$45 copayment	One per year
Hearing aids	$699 copayment per aid for TruHearing Advanced Hearing Aids $999 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

SECTION 5. 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 the member 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 the member's 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 6. ELIGIBILITY

6.1 WHO IS ELIGIBLE FOR COVERAGE

A person is eligible to enroll in the Plan if he or she 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

6.2 DEPENDENT CHILD

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

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

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

SECTION 7. 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.

7.1 ENROLLING ELIGIBLE PERSONS

7.1.1 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 the Group 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.

7.1.2 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 the Group 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 his or her 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.

7.1.3 Continuous Group Coverage

Retirees may enroll by filling out an enrollment request form and submitting it to the Group 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.

7.2 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 the Group fails to pay the required premium
c. The last day of the period for which a member has made the required premium contribution

d. The date a member no longer meets the eligibility requirements of the Plan
e. The first day of the month following a member's written notice of termination of coverage

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

7.3 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

7.4 RESCISSION BY INSURER

Moda Health may rescind a member's coverage back to the effective date, 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 the member's coverage. Material misrepresentation may include but is not limited to enrolling ineligible persons on the Plan, falsifying or withholding documentation or information that is the basis for eligibility, and falsification or alteration of claims. Moda Health reserves the right to retain premiums paid as liquidated damages, and the member shall be responsible for the full balance of any benefits paid. Should Moda Health terminate coverage under this section, Moda Health 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.

7.5 BENEFITS AFTER COVERAGE STOPS

If the Plan is terminated, coverage ends on the date the Plan ends. However, for members who 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 members are not covered.

SECTION 8. CLAIMS ADMINISTRATION AND PAYMENT

8.1 CLAIM FILING

Before the Plan can pay any benefits, the provider of service must file a claim for those expenses with Medicare. Moda Health 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.

Members who live in Oregon should call Customer Service to arrange to have their Medicare claims sent to Moda Health electronically. Members may then submit their claims to Medicare, and Moda Health will automatically be notified of what was paid.

Members who live outside of Oregon will need to send claims, along with the Medicare Explanation of Benefits, to Moda Health.

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.

8.1.1 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, the member must provide all of the following information to Moda Health:

a. Patient's name, member's name, and group and identification numbers
b. Statement explaining where the member was and why he or she 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

8.2 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 the member.

8.2.1 Explanation of Benefits (EOB)

Moda Health will report its action on a claim by providing the member a document called an Explanation of Benefits (EOB). Members are encouraged to access their EOBs electronically by signing up through Member Dashboard. Moda Health may pay claims, deny them, or accumulate them toward satisfying the deductible. If all or part of a claim is denied, the reason will be stated in the EOB.

If the member does not receive an EOB or an email indicating that an EOB is available within a few weeks of the date of service, this may indicate that Moda Health has not received the claim. To be eligible for reimbursement, claims must be received within the claim submission period explained in section 8.1.

8.2.2 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.

8.3 LEGAL ACTIONS

Members 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.

8.4 THIRD-PARTY LIABILITY

A member may have a legal right to recover benefit or healthcare costs from a third party as a result of a medical condition for which such costs were paid by Moda Health. The Plan does not cover benefits for which a third party may be legally liable. Because recovery from a third party may be difficult and take a long time, as a service to the member Moda Health will pay a member's expenses. This is based on the understanding and agreement that Moda Health is entitled to be reimbursed to the extent allowed under Oregon law from any recovery the member may receive for any benefits paid that are or may be recoverable from a third party, as defined below.

The member agrees that Moda Health has the rights described in section 8.4. Moda Health may seek recovery under one or more of the procedures outlined in this section. The member agrees to do whatever is necessary to fully secure and protect, and to do nothing to prejudice, Moda Health's right of recovery or subrogation as discussed in this section. Moda Health has discretion to interpret and construe these recovery and subrogation provisions.

8.4.1 Definitions

For purposes of section 8.4, the following definitions apply:

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

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

Third Party Claim means any claim, lawsuit, settlement, award, verdict, judgment, arbitration decision or other action against a third party (or any right to such an action) by or on behalf of a member.

8.4.2 Subrogation

Upon payment by the Plan, Moda Health has, to the extent consistent with Oregon law, the right to pursue the third party in its own name, or in the name of the member. The member shall do whatever is necessary to secure such rights and do nothing to prejudice them. Moda Health is entitled to all subrogation rights and remedies under the common and statutory law, as well as under the Plan.

8.4.3 Right of Recovery

In addition to its subrogation rights, Moda Health may, at its sole discretion and option, require the member, and his or her attorney, if any, to protect its recovery rights. The following rules apply to this right of recovery:

a. The member holds any rights of recovery against the third party in trust for Moda Health, but only for the amount of benefits Moda Health paid for that medical condition to the extent the amount is consistent with Oregon law.

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

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

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

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

f. In third party claims involving the use or operation of a motor vehicle, Moda Health, at its sole discretion and option, is entitled to seek reimbursement under the Personal Injury Protection statutes of the state of Oregon, including ORS 742.534, ORS 742.536, or ORS 742.538 or under other applicable state law.

8.4.4 Additional Provisions

Members shall comply with the following and agree that Moda Health may do one or more of the following at its discretion:

a. The member shall cooperate with Moda Health to protect its recovery rights, including by:

   i. Signing and delivering any documents Moda Health reasonably requires to protect its rights, including a Third Party Reimbursement Questionnaire and Agreement. If the member has retained an attorney, then the attorney must also sign the agreement.
   ii. Providing any information to Moda Health relevant to the application of the provisions of this section, including all information available to the member, or any representative or attorney representing the member, relating to the potential third party claim. This may include medical information, settlement correspondence, copies of pleadings or demands, and settlement agreements, releases or judgments
   iii. Notifying Moda Health of the potential third party claim for which the Plan may issue benefits. The member has this responsibility even if the first request for payment of benefits is a bill or invoice submitted to Moda Health by the member's service provider.
   iv. Taking such actions as Moda Health may reasonably request to assist it in enforcing its third party recovery rights

b. The member and his or her representatives are obligated to notify Moda Health in advance of any claim (written or oral) and/or any lawsuit made against a third party seeking recovery of any damages from the third party, whether or not the member is seeking recovery of benefits paid by Moda Health from the third party.

c. By accepting payment of benefits by the Plan, the member agrees that Moda Health has the right to intervene in any lawsuit or arbitration filed by or on behalf of a member seeking damages from a third party.

d. The member agrees that Moda Health may notify any third party, or third party's representatives or insurers, of its recovery rights described in section 8.4.

e. Even without the member's written authorization, Moda Health may release to, or obtain from, any other insurer, organization or person, any information it needs to carry out reimbursement from third party recoveries and the provisions of section 8.4.

f. Section 8.4 applies to any member for whom advance payment of benefits is made by Moda Health whether or not the event giving rise to the member's injuries occurred before the member became covered by Moda Health.

g. Coordination of benefits, where the member has healthcare coverage under more than one plan or health insurance policy, is not considered a third party claim.

h. If any term, provision, agreement or condition is held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions shall remain in full force and effect and shall in no way be affected, impaired or invalidated.

SECTION 9. MISCELLANEOUS PROVISIONS

9.1 WHEN MEDICARE IS SECONDARY

The Plan coordinates benefits with Medicare Part A and B as allowed under federal government rules and regulations. 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 Part A and Part B benefits had not been reduced. Nevertheless, the Plan may reduce its benefits so that the total benefits paid by all plans are not more than the total allowable expense.

9.2 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.

9.3 EFFECT OF CHANGE OF PLAN

If on the effective date the member has 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.

9.4 MEDICAID

Benefits and premiums under the Plan will be suspended during a member's 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 the member makes a request for reinstatement within 90 days of the date he or she is 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.

9.5 RECOVERY OF BENEFITS PAID BY MISTAKE

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

9.6 CONFIDENTIALITY OF MEMBER INFORMATION

The confidentiality of the member's protected health information is of extreme importance to Moda Health. Protected health information includes, but is not limited to enrollment, claims, and medical and dental information. Moda Health uses such information internally for claims payment, referrals and authorization of services, and business operations such as case management and quality management programs. Moda Health does not sell this information. The Notice of Privacy Practices provides more complete detail about how Moda Health uses members' information. A copy of the notice is available on the Moda Health website by following the HIPAA link or by calling 503-243-4492.

Moda does not discriminate

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

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

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

If you need any of the above, call:

Medicare Customer Service,
877-299-9062 (TDD/TTY 711)

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

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

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

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

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

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

Dave Nesseler-Cass coordinates our nondiscrimination work:

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

moda HEALTH

DELTA DENTAL
Delta Dental of Oregon & Alaska

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

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

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

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

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

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

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

ATANSYON: Si ou pale Kreyòl Ayisyen, nou ofri sèvis gratis pou ede w nan lang ou pale a. Rele nan 1-877-605-3229 (moun ki itilize sistèm TTY rele : 711)

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

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

ATENÇÃO: Caso fale português, estão disponíveis serviços gratuitos de ajuda linguística. Telefone para 1-877-605-3229 (TERMINAL: 711)

ATTENZIONE: Se parla italiano, sono disponibili per lei servizi gratuiti di assistenza linguistica. Chiamare il numero 1-877-605-3229 (TTY: 711)

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

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

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

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

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

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

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

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

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

modahealth.com

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

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