Oregon Group Vision Plan

City of Albany

Effective Date: July 1, 2020
Group Number: 10000128

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

ModaORVisBk 1-1-2020 (10000128)

TABLE OF CONTENTS

SECTION 1. WELCOME 1

SECTION 2. MEMBER RESOURCES 2

2.1 CONTACT INFORMATION 2
2.2 MEMBERSHIP CARD 2
2.3 NETWORK INFORMATION 2
2.4 OTHER RESOURCES 2

SECTION 3. BENEFIT DESCRIPTION 3

3.1 COVERED PROVIDERS 3
3.2 COVERED SERVICES AND SUPPLIES 3

SECTION 4. EXCLUSIONS 4

SECTION 5. ELIGIBILITY 7

5.1 SUBSCRIBER 7
5.2 DEPENDENTS 7
5.3 QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) 8
5.4 NEW DEPENDENTS 8
5.5 ELIGIBILITY AUDIT 8

SECTION 6. ENROLLMENT 9

6.1 ENROLLING ELIGIBLE EMPLOYEES 9
6.2 ENROLLING NEW DEPENDENTS 9
6.3 OPEN ENROLLMENT 9
6.4 SPECIAL ENROLLMENT RIGHTS 9
6.4.1 Loss of Other Coverage 9
6.4.2 Eligibility for Premium Subsidy 10
6.4.3 New Dependents 10
6.5 WHEN COVERAGE BEGINS 10
6.6 WHEN COVERAGE ENDS 11
6.6.1 Termination of the Group Plan 11
6.6.2 Termination by Subscriber 11
6.6.3 Death 11
6.6.4 Termination, Layoff or Reduction in Hours of Employment 11
6.6.5 Loss of Eligibility by Dependent 12
6.6.6 Rescission 12
6.6.7 Continuing Coverage 12

SECTION 7. CLAIMS ADMINISTRATION & PAYMENT 13

7.1 SUBMISSION & PAYMENT OF CLAIMS 13
7.1.1 Claim Submission 13
7.1.2 Explanation of Benefits (EOB) 13
7.1.3 Claim Inquiries 13
7.1.4 Time Frames for Processing Claims 14
7.2 APPEALS 14
7.2.1 Definitions 14
7.2.2 Time Limit for Submitting Appeals 14
7.2.3 The Review Process 14
7.2.4 First Level Appeals 15

7.2.5 Second Level Appeals 15
7.3 Benefits Available from Other Sources 15
7.3.1 Coordination of Benefits (COB) 15
7.3.2 Third Party Liability 19
7.3.3 Motor Vehicle Accident Recovery 22

SECTION 8. MISCELLANEOUS PROVISIONS 23

8.1 Right to Collect & Release Needed Information 23
8.2 Confidentiality of Member Information 23
8.3 Transfer of Benefits 23
8.4 Recovery of Benefits Paid by Mistake 23
8.5 Correction of Payments 23
8.6 Contract Provisions 24
8.7 Responsibility for Quality of Vision Care 24
8.8 Warranties 24
8.9 No Waiver 24
8.10 Group is the Agent 24
8.11 Governing Law 24
8.12 Where any Legal Action Must be Filed 25
8.13 Time Limits for Filing a Lawsuit 25
8.14 Evaluation of New Technology 25

SECTION 9. CONTINUATION OF VISION COVERAGE 26

9.1 Oregon Continuation for Spouses & Domestic Partners Age 55 and Over 26
9.1.1 Introduction 26
9.1.2 Eligibility 26
9.1.3 Notice & Election Requirements 26
9.1.4 Premiums 27
9.1.5 When Coverage Ends 27
9.2 COBRA Continuation Coverage 27
9.2.1 Introduction 27
9.2.2 Qualifying Events 27
9.2.3 Continuation Upon Retirement 28
9.2.4 Other Coverage 29
9.2.5 Notice & Election Requirements 29
9.2.6 COBRA Premiums 30
9.2.7 Length of Continuation Coverage 30
9.2.8 Extending the Length of COBRA Coverage 31
9.2.9 Special Enrollment & Open Enrollment 32
9.2.10 When Continuation Coverage Ends 32
9.3 Uniformed Services Employment & Reemployment Rights Act (USERRA) 32
9.4 Family & Medical Leave 33
9.5 Strike or Lockout 34

SECTION 10. ERISA DUTIES 35

10.1 Plan Administrator as Defined Under ERISA 35
10.2 Information about the Plan and Benefits 35
10.3 Continuation of Group Vision Coverage 35
10.4 Prudent Actions by Plan Fiduciaries 35
10.5 Enforcement of Rights 36
10.6 Assistance with Questions 36

SECTION 11. DEFINITIONS 37

SECTION 1. WELCOME

Moda Health is pleased to have been chosen by the Group as its vision benefit plan. This handbook is designed to provide members with important information about the Plan's benefits, limitations and procedures.

Members may direct questions to one of the numbers listed in Section 2 or access tools and resources on Moda Health's personalized member website, myModa, at www.modahealth.com. myModa is available 24 hours a day, 7 days a week, allowing members to access plan information whenever it is convenient.

Moda Health reserves the right to monitor telephone conversations and email communications between its employees and its members for legitimate business purposes as determined by Moda Health.

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 myModa, 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. MEMBER RESOURCES

2.1 CONTACT INFORMATION

Moda Health Website (log in to myModa)
www.modahealth.com
Includes Find Care (use to find an in-network provider)

Customer Service Department
888-217-2363
En Español 888-786-7461

Telecommunications Relay Service for the hearing impaired
711

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

2.2 MEMBERSHIP CARD

After enrolling, members will receive ID (identification) cards that include the group and identification numbers, and the network name. Members will need to present their card each time they receive services. Members may go to myModa or contact Customer Service for replacement of a lost ID card.

2.3 NETWORK INFORMATION

Vision benefits can be maximized by using an in-network vision provider. Members may choose an in-network vision provider by using Find Care on myModa or by contacting Customer Service for help.

Network
For all members:
Connexus, with providers in Oregon and southwest Washington

When members use vision providers that are not in-network, if the charges are more than the in-network negotiated rates, the member is responsible for paying those excess charges. In most cases the member must pay the provider at the time of treatment, and then file a claim to be reimbursed.

2.4 OTHER RESOURCES

Additional member resources providing general information about the Plan can be found in Section 8 and Section 10.

SECTION 3. BENEFIT DESCRIPTION

The Plan covers vision examinations and corrective lenses and frames once per calendar year for members through the end of the month in which they reach age 19. For members age 19 and over, the benefits are paid up to a $400 annual maximum for corrective lenses and frames.

Payment is based on the contracted fee for in-network providers and billed charges for out-of-network providers.

3.1 COVERED PROVIDERS

Vision care can be prescribed by a licensed ophthalmologist or licensed optometrist. Members may choose any licensed ophthalmologist, optician, optometrist or hardware provider for services. Moda Health has a broad panel of in-network vision providers (see section 2.3). Members will maximize their benefits by using these providers for vision services.

3.2 COVERED SERVICES AND SUPPLIES

The following services are covered:

a. One complete eye exam, including the charge for refraction, after a $20 copay
b. Frames for corrective lenses
c. Corrective lenses for eyeglasses or contact lenses.

SECTION 4. EXCLUSIONS

In addition to the limitations and exclusions described elsewhere in the Plan, the following services, procedures and conditions are not covered, even if otherwise medically necessary or if recommended, referred or provided by a vision provider. Any direct complication or consequence that arises from these exclusions will not be covered.

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

Care Outside the United States
Scheduled care or care that is not due to an urgent or emergency medical condition

Experimental or Investigational Procedures
Including expenses incidental to or incurred as a direct consequence of such procedures (see definition of experimental/investigational in Section 11)

Illegal Acts, Riot or Rebellion, War
Services or supplies for treatment of a vision condition caused by or arising out of a member's voluntary participation in a riot or arising directly from the member's illegal act. This includes any expense caused by, arising out of or related to declared or undeclared war, including civil war, martial law, insurrection, revolution, invasion, bombardment or any use of military force or usurped power by any government, military or other authority.

Inmates
Services and supplies a member receives while in the custody of any state or federal law enforcement authorities or while in jail or prison

Medical or Surgical Treatment of the Eyes or Supporting Structures

Missed Appointments

Nonprescription Lenses
Including nonprescription sunglasses

Reports and Records
Including charges for the completion of claim forms

Safety Eyewear
Unless lenses are corrective

Service Related Conditions
Treatment of any condition caused by or arising out of a member's service in the armed forces of any country or as a military contractor or from an insurrection or war, unless not covered by the member's military or veterans coverage

Services Otherwise Available
Including those:

a. for which payment could be obtained in whole or in part if a member had applied for payment under any city, county, state, or federal law, except for Medicaid coverage
b. for which a member cannot be held liable because of an agreement between the vision provider and another third party payer which has paid or is obligated to pay for such service or supply
c. for which no charge is made, or for which no charge is normally made in the absence of insurance, including an expense a member did not have to pay due to discounts received or other promotions
d. provided under separate contracts that are used to provide coordinated coverage for covered persons in a group and are considered parts of the same plan
e. a member could have received in a hospital or program operated by a government agency or authority. This exclusion does not apply to:
    i. covered services rendered at any hospital owned or operated by the state of Oregon
    ii. veterans of the armed forces, in which case covered services and supplies furnished by the Veterans' Administration of the United States that are not service related are eligible for payment according to the terms of the Plan

Services Provided or Ordered by a Relative
Relatives, for the purpose of this exclusion, include a member or a spouse or domestic partner, child, sibling, or parent of a member or his or her spouse or domestic partner

Services Provided by Volunteer Workers

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

Surgery to Alter Refractive Character of the Eye
Any procedure to cure or reduce myopia, hyperopia or astigmatism. Includes reversals or revisions of any such procedures and any complications of these procedures.

Taxes

Telehealth

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

Treatment After Coverage Ends

Treatment Before Coverage Begins

Treatment Not Medically Necessary
Including services or supplies that are:

a. Not medically necessary for the treatment of a condition otherwise covered under the Plan
b. Inappropriate or inconsistent with the symptoms or diagnosis of a member's condition
c. Not established as the standard treatment by the medical community in the service area in which they are received
d. Primarily rendered for the convenience of a member or a vision provider

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

Vitamin Therapy

Work Related Conditions
Treatment of a medical condition arising out of or in the course of employment or self-employment for wages or profit, whether or not the expense is paid 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 5. ELIGIBILITY

The date a person becomes eligible may be different than the date coverage begins (see section 6.5).

5.1 SUBSCRIBER

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

a. is a permanent documented full-time employee, sole proprietor, owner, business partner or corporate officer of the Group
b. regularly works the required hours as specified by City of Albany
c. is not a leased, substitute, or temporary employee, or an agent, consultant or independent contractor. A seasonal employee is not eligible unless defined as a full-time employee under the terms of the Affordable Care Act
d. is paid on a regular basis through the payroll system, has federal taxes deducted from such pay and is reported to Social Security
e. satisfies any orientation and/or eligibility waiting period

Subscribers are eligible to remain enrolled if they are on an approved leave of absence under state or federal family and medical leave laws.

5.2 DEPENDENTS

A subscriber's legal spouse or domestic partner (see addendum) is eligible for coverage. A subscriber's children are eligible until their 26th birthday. Children eligible due to a court or administrative order are subject to the Plan's child age limit.

For purposes of determining eligibility, the following are considered children:

a. The biological or adopted child of a subscriber or a subscriber's eligible spouse or domestic partner
b. Children placed for adoption with a subscriber. Adoption paperwork must be provided
c. A newborn child of an enrolled dependent for the first 31 days of the newborn's life
d. Children related to a subscriber by blood or marriage for whom the subscriber is the legal guardian. A court order showing legal guardianship must be provided

A subscriber's child who has sustained a disability making 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 be unmarried and principally dependent on the subscriber for support, and have had continuous vision 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. Relevant recent hospitalization records (e.g., history and physical, discharge summary)
d. Disability information from prior carrier

Moda Health will make a determination based on documentation of the child's medical condition. Periodic review by Moda Health will be required on an ongoing basis except in cases where the disability is certified to be permanent.

5.3 QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

The Plan will cover a child of an eligible employee who has a right to enrollment due to a qualified medical child support order (QMCSO). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. A copy of such procedures is available from the Group without charge.

The child's coverage under the Plan will be effective as of the first day of the month following the date that the Group determines that applicable order qualifies as a QMCSO, and that the child is eligible for enrollment in the Plan.

5.4 NEW DEPENDENTS

A new dependent may cause a premium increase. Premiums will be adjusted accordingly and will apply from the date coverage is effective.

If a subscriber marries or registers a domestic partnership, the spouse or domestic partner and his or her children are eligible to enroll as of the date of the marriage or registration. If a subscriber files an Affidavit of Domestic Partnership with the Group the domestic partner and his or her children are eligible for coverage.

A member's newborn child is eligible from birth. A subscriber's adopted child, or a child placed for adoption, will be eligible on the date of placement. To enroll a new child, an application must be submitted. When a premium increase is required, the application and payment must be submitted within 31 days. If payment is required but not received, the child will not be covered. Proof of legal guardianship will be required for coverage of a grandchild beyond the first 31 days from birth.

5.5 ELIGIBILITY AUDIT

Moda Health reserves the right to conduct audits to verify a member's eligibility, and may request documentation including but not limited to employee timecards, member birth certificates, adoption paperwork, marriage certificates, domestic partnership registration and any other evidence necessary to document eligibility on the Plan.

SECTION 6. ENROLLMENT

6.1 ENROLLING ELIGIBLE EMPLOYEES

A complete and signed application for the eligible employee and any dependents to be enrolled must be filed with the Group within 31 days of becoming eligible to apply for coverage. Eligible employees can apply on the date of hire or the end of any required waiting period.

The subscriber must notify the Group and Moda Health of any change of address.

6.2 ENROLLING NEW DEPENDENTS

To enroll a new dependent, a complete and signed application and, when applicable, a marriage certificate, domestic partnership documentation, or adoption or placement for adoption paperwork must be submitted within 31 days of their eligibility. The subscriber must notify Moda Health if family members are added or dropped from coverage, even if it does not affect premiums.

6.3 OPEN ENROLLMENT

If an eligible employee and/or any eligible dependents are not enrolled within 31 days of first becoming eligible, they must wait for the next open enrollment period to enroll unless they meet one of the eligibility requirements as described in section 6.4. Open enrollment occurs once a year at renewal.

6.4 SPECIAL ENROLLMENT RIGHTS

The special enrollment rights as described in sections 6.4.1 and 6.4.2 apply:

a. To an eligible employee who loses other coverage or becomes eligible for a premium assistance subsidy
b. To a subscriber's dependent who loses other coverage or becomes eligible for a premium assistance subsidy
c. To both the eligible employee and his or her dependent if neither is enrolled in the Plan, and either loses other coverage or becomes eligible for a premium assistance subsidy

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

6.4.1 Loss of Other Coverage

If coverage is declined when initially eligible or at an open enrollment period because of other vision coverage, an eligible employee or any dependents may enroll in the Plan outside of the open enrollment period if the following criteria are met:

a. He or she was covered under a group vision plan or had vision coverage at the time coverage was previously offered
b. He or she stated in writing at such time that coverage under a group vision plan or vision coverage was the reason enrollment was declined
c. He or she requests such enrollment not later than 31 days after the previous coverage ended (except for event iv. below, which allows up to 60 days)
d. One of the following events has occurred:
    i. His or her prior coverage was under a COBRA continuation provision and the coverage under such provision was exhausted
    ii. His or her prior coverage ended as a result of loss of eligibility for the coverage. Examples of when coverage under a plan may be lost include:
        A. legal separation or divorce
        B. loss of dependent status per plan terms
        C. death
        D. end of employment or reduction in the number of hours of employment
        E. the plan stops offering coverage to a group of similarly situated persons
        F. moving out of an HMO service area that causes coverage to end and no other option is available under the plan
        G. termination of the benefit package option, and no substitute option is offered
    iii. The employer contributions toward his or her other active (not COBRA) coverage end. (If employer contributions stop, the eligible employee or dependent does not have to end coverage to be eligible for special enrollment on a new plan.)
    iv. His or her prior coverage was under Medicaid or a children's health insurance program (CHIP) and such coverage ended due to loss of eligibility. Special enrollment must be requested within 60 days of the end of coverage.

6.4.2 Eligibility for Premium Subsidy

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

6.4.3 New Dependents

An eligible employee, spouse or domestic partner and children will have special enrollment rights if they are not enrolled at the time of the event that caused the eligible employee person to gain a new dependent (e.g., marriage, domestic partnership, birth, adoption, placement for adoption).

6.5 When Coverage Begins

Coverage for subscribers begins on the enrollment date or after a waiting period, as specified in the policy.

Coverage for new dependents through marriage, registration of a domestic partnership, or the filing of an Affidavit of Domestic Partnership with the Group begins on the date of marriage or partnership if the marriage, registration or filing date is the first day of the month. Otherwise, coverage begins on the first day of the month following the date of marriage, registration or filing.

Coverage for a newborn is effective on the date of the newborn's birth. Coverage for a child newly adopted or placed for adoption is effective on the date of adoption or placement. Court ordered coverage is effective on the first day of the month following the date the Group determines that an applicable order qualifies as a QMCSO and that the child is eligible for enrollment in the Plan.

Coverage for those enrolling during open enrollment begins on the date the Plan renews. All other plan provisions will apply. Coverage under special enrollment due to loss of coverage or eligibility for premium subsidy begins on the first day of the month following receipt of the special enrollment request, or coinciding with, but not before the loss of other coverage.

The necessary premiums must also be paid for coverage to become effective.

6.6 WHEN COVERAGE ENDS

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

6.6.1 Termination of the Group Plan

Coverage ends for the Group and members on the date the Plan ends.

6.6.2 Termination by Subscriber

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

6.6.3 Death

If a subscriber dies, coverage for any enrolled dependents ends on the last day of the month in which the death occurs. Enrolled dependents may extend their coverage if the requirements for continuation of coverage are met (see Section 9). The Group must notify Moda Health of any continuation of coverage, and appropriate premiums must be paid along with the Group's regular monthly payment.

6.6.4 Termination, Layoff or Reduction in Hours of Employment

Coverage ends on the last day of the month in which employment ends, unless a member chooses to continue coverage (see Section 9).

If a subscriber

a. is laid off by the Group; or
b. experiences a reduction in hours that causes loss of coverage

And within 6 months the subscriber

a. returns to active work; or
b. has an increase in hours to qualify for benefits

The subscriber and any eligible dependents may enroll in the Plan on the date of rehire or the date the subscriber works enough hours to qualify for benefits and coverage will begin on that date. The Group must notify Moda Health that a subscriber has been rehired following a layoff or that a subscriber's hours have been increased, and the necessary premiums for coverage must be paid.

6.6.5 Loss of Eligibility by Dependent

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

a. Coverage ends for an enrolled spouse on the last day of the month in which a decree of divorce or annulment is entered (regardless of any appeal), and for an enrolled domestic partner on the last day of the month in which a judgment of dissolution or annulment of the domestic partnership has been entered or that the partnership no longer meets the requirements of the Affidavit of Domestic Partnership.
b. Coverage ends for an enrolled child on the last day of the month in which he or she reaches age 26, or that a legal guardianship ends.
c. The subscriber and the unregistered domestic partner are required to give written notice to the Group within 31 days of any change in the requirements met.

The subscriber must notify Moda Health when a marriage, domestic partnership or guardianship ends.

Enrolled dependents may have the right to continue coverage in their own names when their coverage under the Plan ends. An enrolled child of a domestic partner will lose eligibility upon termination of the domestic partnership.

6.6.6 Rescission

Moda Health may rescind a member's coverage back to the effective date, or deny claims at any time for fraud or intentional material misrepresentation by the member or the Group. This 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 or employment, and falsification or alteration of claims. Moda Health reserves the right to retain premiums paid as liquidated damages, and the Group and/or member shall be responsible for the full balance of any benefits paid. Moda Health will notify a member of a rescission 30 days before cancellation of coverage.

6.6.7 Continuing Coverage

Information is in Continuation of Vision Coverage (Section 9).

SECTION 7. CLAIMS ADMINISTRATION & PAYMENT

7.1 SUBMISSION & PAYMENT OF CLAIMS

A claim is not payable until the service or supply has actually been received. 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 date the expense was incurred. Claims submitted by Medicaid must be sent to Moda Health within 3 years after the date the expense was incurred.

7.1.1 Claim Submission

A vision provider will often bill charges directly to Moda Health when the member shows his or her Moda Health identification card to the treating office. Moda Health will pay the provider and send copies of its payment record to the member. The provider will then bill the member for any charges that were not covered.

Sometimes, a vision provider will require a member to pay charges for a service that the provider believes is not a covered expense. If this happens, the member must pay these amounts if he or she wishes to accept the service. Moda Health will reimburse the member if any of the charges paid are later determined to be covered by the Plan.

When a member is billed by the vision provider directly, he or she should send a copy of the bill to Moda Health and include all of the following information:

a. Patient's name
b. Subscriber's name and group and identification numbers
c. Date of service
d. Diagnosis with corresponding current ICD codes
e. Itemized description of the services and charges with corresponding American Medical Association CPT and/or Centers for Medicare and Medicaid HCPCS codes
f. Provider's tax ID number

7.1.2 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 myModa. Moda Health may pay claims or deny them. If all or part of a claim is denied, the reason will be stated in the EOB.

If a 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 7.1.1.

7.1.3 Claim Inquiries

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

7.1.4 Time Frames for Processing Claims

If a claim is denied, Moda Health will send an EOB explaining the denial within 30 days after receiving the claim. If more time is needed to process the claim for reasons beyond Moda Health's control, a notice of delay will be sent to the member explaining those reasons within 30 days after Moda Health receives the claim. Moda Health will then finish processing the claim and send an EOB to the member no more than 45 days after receiving the claim. If more information is needed to process the claim, the notice of delay will describe the information needed and the party responsible for providing the additional information will have 45 days to submit it. Once the additional information is received, processing of the claim will be completed within 15 days. Submission of information necessary to process a claim is subject to the Plan's claim submission period explained in Section 7.1.1.

7.2 APPEALS

Before filing an appeal, it may be possible to resolve a dispute with a phone call to Customer Service.

7.2.1 Definitions

For purposes of section 7.2, the following definitions apply:

Adverse Benefit Determination means a letter or an Explanation of Benefits (EOB) from Moda Health informing that a person is not eligible for benefits or that benefits have not been fully paid. Reasons are:

a. Rescission of coverage (section 6.6.6)
b. Eligibility to participate in the Plan
c. Utilization review (described below)
d. Decision that an item or service is experimental or investigational or not necessary

Appeal is a written request by a member or his or her representative for Moda Health to review an adverse benefit determination.

Utilization Review means a system of reviewing the medical necessity, appropriateness, or quality of medical care services and supplies. An adverse benefit determination that the item or service is not medically necessary or appropriate, is investigational or experimental, or in which the decision as to whether a benefit is covered involved a medical judgment is a utilization review decision.

7.2.2 Time Limit for Submitting Appeals

A member has **180 days** from the date an adverse benefit determination is received to submit the first written appeal. If appeals are not submitted within the timeframes in these sections, the member will lose the right to any appeal.

7.2.3 The Review Process

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

The timelines in the sections below do not apply when the member does not reasonably cooperate, or circumstances beyond the control of either party (Moda Health or the member)

makes it impossible to comply with the requirements. Whoever is unable to comply must give notice of the specific reason to the other party when the issue arises.

Upon request, and free of charge, the member may have reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits.

7.2.4 First Level Appeals

An appeal must be submitted in writing. If necessary, Customer Service can help with filing an appeal. Written comments, documents, records and other information about the claim for benefits may be submitted. Moda Health will send a letter no more than 7 days after receiving an appeal to tell the member that the appeal is received. Appeals are investigated by persons who were not involved in the original decision.

When an investigation is finished, Moda Health will send a written notice of the decision to the member, including the reason for the decision. This notice will be sent within 30 days of the appeal.

7.2.5 Second Level Appeals

A member who disagrees with the decision on the first level appeal may ask for a review of the decision. The second level appeal must be submitted in writing within 60 days of the date of Moda Health's action on the first level appeal.

Investigations and responses to a second level appeal will be by persons who were not involved in the initial decisions and will follow the same timelines as those for a first level appeal. The member will have the option to submit written comments, documents, records and other information about the appeal that were not submitted before.

7.3 BENEFITS AVAILABLE FROM OTHER SOURCES

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

7.3.1 Coordination of Benefits (COB)

Coordination of benefits applies when a member has vision coverage under more than one plan.

If the member is covered by another plan or plans, the benefits under this Plan and the other plan(s) will be coordinated. This means one plan pays its full benefits first, and then any other plans pay. The order of benefit determination rules govern the order in which each plan will pay a claim for benefits.

7.3.1.1 Order of Benefit Determination (Which Plan Pays First?)

The first of the following rules that applies will govern:

a. **Non-dependent/Dependent.** If a plan covers the member as other than a dependent (e.g., an employee, member of an organization, primary insured or retiree), then that plan will determine its benefits before a plan that covers the member as a dependent.
b. **Dependent Child/Parents Married or Living Together.** If the member is a dependent child whose parents are married or are living together whether or not they have ever been married or domestic partners, the plan of the parent whose birthday falls earlier in the

calendar year is the primary plan. If both parents' birthdays are on the same day, the plan that has covered the parent the longest is the primary plan (this is called the birthday rule.)

c. **Dependent Child/Parents Separated or Divorced or Not Living Together.** If the member is a dependent child of divorced or separated parents, or parents not living together whether or not they have ever been married or domestic partners, then the following rules apply:
   i. If a court decree states that one of the parents is responsible for the healthcare expenses of the child, and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree.
   ii. If a court decree states that both parents are responsible for the healthcare expenses of the child, or that the parents have joint custody without specifying that one parent is responsible, the birthday rule described above applies.
   iii. If there is not a court decree allocating responsibility for the child's healthcare expenses, the order of benefits is as follows: The plan covering the
      A. Custodial parent
      B. Spouse or domestic partner of the custodial parent
      C. Non-custodial parent
      D. Spouse or domestic partner of the non-custodial parent

d. **Dependent Child Covered by Individual Other than Parent.** For a dependent child covered under more than one plan of persons who are not the parents of the child, the first applicable provision (b. or c.) above shall determine the order of benefits as if those persons were the parents of the child.

e. **Dependent Child Covered by Parent and Spouse/Domestic Partner.** For a dependent child covered under the plans of both a parent and a spouse or domestic partner, the length of coverage provision below shall determine the order of benefits. If coverage under either or both parents' plans and the spouse's/domestic partner's plan began on the same day, the birthday rule will apply.

f. **Active/Retired or Laid Off Employee.** The plan that covers a member as an active employee (i.e., one who is neither laid off nor retired) or as that employee's dependent determines its benefits before those of a plan that covers the member as a laid off or retired employee or as that employee's dependent. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored.

g. **COBRA or State Continuation Coverage.** If a member whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the member as an employee, member of an organization, primary insured, or retiree or as a dependent of the same, is the primary plan and the COBRA or other continuation coverage is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored.

h. **Longer/Shorter Length of Coverage.** The plan that covered a member longer is the primary plan and the plan that covered the member for the shorter period of time is the secondary plan.

i. **None of the Above.** If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans. In addition, this Plan will not pay more than it would have paid if it had been the primary plan.

7.3.1.2 How COB Works

The **primary plan** (the plan that pays benefits first) pays the benefits that would be payable under its terms in the absence of this provision.

The **secondary plan** (the plan that pays benefits after the primary plan) will reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense.

This Plan will coordinate with a plan that is "excess" or "always secondary" or that uses order of benefit determination rules that are inconsistent with those contained in OAR 836-020-0770 to 836-020-0805 (non-complying plan) on the following basis:

a. If this Plan is primary, it will provide its benefits first
b. If this Plan is secondary and the non-complying plan does not provide its primary payment information within a reasonable time after it is requested to do so, this Plan will assume that the benefits of the non-complying plan are identical to this Plan's benefits. This Plan will provide its benefits first, but the amount of the benefits payable shall be determined as if this Plan were the secondary plan
c. If the non-complying plan reduces its benefits so that the member receives less in benefits than he or she would have received had this Plan provided its benefits as the secondary plan and the non-complying plan provided its benefits as the primary plan, then this Plan shall advance additional benefits equal to the difference between the amount that was actually paid and the amount that should have been paid if the non-complying plan had not improperly reduced its benefits. Additional payment will be limited so that this Plan will not pay any more than it would have paid if it had been the primary plan. In consideration of such an advance, this Plan shall be subrogated to all rights of the member against the non-complying plan.

7.3.1.3 Effect on the Benefits of this Plan

In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other vision coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other vision coverage.

If the primary plan is a closed panel plan and the member uses an out-of-network provider, the secondary plan shall provide benefits as if it were the primary plan, except for emergency services or authorized referrals that are paid or provided by the primary plan.

7.3.1.4 Definitions

For purposes of section 7.3.1, the following definitions apply:

Plan means any of the following that provides benefits or services for vision care or treatment. If separate contracts are used to provide coordinated coverage for covered persons in a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

Plan includes:

a. Group or individual insurance contracts and group-type contracts
b. HMO (health maintenance organization) coverage

c. Coverage under a labor-management trusteed plan, a union welfare plan, an employer organization plan or an employee benefits plan
d. Medicare or other government programs, other than Medicaid, and any other coverage required or provided by law
e. Other arrangements of insured or self-insured group or group-type coverage

Plan does not include:

a. Fixed indemnity coverage
b. Accident-only coverage
c. Specified disease or specified accident coverage
d. School accident coverage
e. Benefits for non-medical components of group long-term care policies
f. Medicare supplement policies
g. Medicaid policies
h. Coverage under other federal governmental plans, unless permitted by law

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

Complying plan is a plan that follows these COB rules.

Non-complying plan is a plan that does not follow these COB rules.

Claim means a request that benefits of a plan be provided or paid.

Allowable expense means a vision expense, including cost sharing, that is covered at least in part by any plan covering the member. When a plan provides benefits in the form of a service instead of cash payments, the reasonable cash value of the service will also be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the member is not an allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a member is not an allowable expense.

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

a. The amount of the reduction by the primary plan because a member has not complied with the plan's requirements concerning prior authorization or because the member has a lower benefit due to not using an in-network provider
b. Any amount in excess of the highest reimbursement amount for a specific benefit, if a member is covered by 2 or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology
c. Any amount in excess of the highest of the negotiated fees, if a member is covered by 2 or more plans that provide benefits or services on the basis of negotiated fees
d. If a member is covered by one plan that calculates its benefits on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits on the basis of negotiated fees, the primary plan's arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than

the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

This Plan is the part of this policy that provides benefits for vision expenses to which the COB provision applies and which may be reduced because of the benefits of other plans.

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

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

7.3.2 Third Party Liability

A member may have a legal right to recover benefit or vision care costs from a third party as a result of an illness or injury for which such costs were paid by Moda Health. The Plan does not cover benefits for which a third party may be legally liable, except for those related to a motor vehicle accident (see section 7.3.3 for motor vehicle accident recovery). 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 based on the understanding and agreement that Moda Health is entitled to be reimbursed 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 7.3.2. 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.

7.3.2.1 Definitions:

For purposes of section 7.3.2, the following definitions apply:

Benefits means any amount paid by Moda Health, or submitted to Moda Health for payment to or on behalf of a 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 a medical condition, of a 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.

7.3.2.2 Subrogation

Upon payment by the Plan, Moda Health has 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 subrogation rights and do nothing to prejudice them. Moda Health is entitled to all subrogation rights and remedies under common and statutory law, as well as under the Plan.

7.3.2.3 Right of Recovery

In addition to its subrogation rights, Moda Health may, at its sole discretion and option, require a member, and his or her attorney, if any, to protect its recovery rights. The following rules apply to all recovery except for those related to motor vehicle accidents (see section 7.3.3 for motor vehicle recovery rights):

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 vision services related to that illness or injury.

b. Moda Health is entitled to receive the amount of benefits it has paid for vision services related to an illness or injury 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 it has paid whether the vision 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 full amount of the benefits paid or pending payment by Moda Health, out of any recovery made by the member from the third party, 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 vision expenses of the member), regardless of the characterization of the recovery, whether or not the member is made whole, 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.

7.3.2.4 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 section 7.3.2, 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 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 7.3.2.

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 the provisions of section 7.3.2.

f. Section 7.3.2 applies to any member for whom advance payment of benefits is made by the Plan whether or not the event giving rise to the member's injuries occurred before the member became covered by Moda Health.

g. If the member continues to receive vision treatment for a condition after obtaining a settlement or recovery from a third party, the Plan will provide benefits for the vision services related to that medical condition only to the extent that the member can establish that any sums that may have been recovered from the third party have been exhausted.

h. If the member or the member's representatives fail to do any of the above mentioned acts, then Moda Health has the right to not advance payment or to suspend payment of any benefits, or to recover any benefits it has advanced, for any medical condition resulting from the event giving rise to, or the allegations in, the third party claim except for claims related to motor vehicle accidents (see section 7.3.3). Moda Health may notify vision providers seeking authorization of payment of benefits that all payments have been suspended and may not be paid.

i. Coordination of benefits (where the member has vision coverage under more than one plan or health insurance policy) is not considered a third party claim.

7.3.3 Motor Vehicle Accident Recovery

If a claim for healthcare expenses arising out of a motor vehicle accident is filed with Moda Helath and motor vehicle insurance has not yet paid, the Moda Health will advance benefits. Moda Health retains the right to repayment of any benefits paid from the proceeds of any settlement, judgement or other payment received by the member that exceeds the amount that fully compensates the member for their motor vehicle accident related injuries.

If Moda Health requires the member or 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.

The member shall do whatever is proper to secure, and may not prejudice, the rights of Moda Health under this section.

SECTION 8. MISCELLANEOUS PROVISIONS

8.1 RIGHT TO COLLECT & RELEASE NEEDED INFORMATION

In order to receive benefits, the member must give or authorize a provider to give Moda Health any information needed to pay benefits. Moda Health may release to or collect from any person or organization any needed information about the member.

8.2 CONFIDENTIALITY OF MEMBER INFORMATION

Keeping a member's protected health information confidential is very important to Moda Health. Protected health information includes enrollment, claims and medical 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 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 855-425-4192.

8.3 TRANSFER OF BENEFITS

Only members are entitled to benefits under the Plan. These benefits are not assignable or transferable to anyone else. Any attempted assignment or transfer will not be binding on Moda Health, except that Moda Health shall pay amounts due under the Plan directly to a provider when billed by a provider licensed, certified or otherwise authorized by laws in the state of Oregon or upon the member's written request.

8.4 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 vision provider. Moda Health's right to recovery includes the right to deduct the amount paid by mistake from future benefits it would provide for a member even if the mistaken payment was not made on that member's behalf.

8.5 CORRECTION OF PAYMENTS

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

8.6 CONTRACT PROVISIONS

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

8.7 RESPONSIBILITY FOR QUALITY OF VISION CARE

In all cases, members have the exclusive right to choose their vision provider. Moda Health is not responsible for the quality of vision care a member receives, since all those who provide care do so as independent contractors. Moda Health cannot be held liable for any claim for damages connected with injuries a member suffers while receiving vision services or supplies.

8.8 WARRANTIES

All statements made by the Group or a member, unless fraudulent, are considered representations and not warranties. No statement made for the purpose of obtaining coverage will void the coverage or reduce benefits unless contained in a written form and signed by the Group or the member, a copy of which has been given to the Group or member or the member's beneficiary.

8.9 NO WAIVER

Any waiver of any provision of the Plan or any performance under the Plan must be in writing and signed by the waiving party. Any such waiver shall not operate as, or be deemed to be, a waiver of any prior or future performance or enforcement of that provision or any other provision. If Moda Health delays or fails to exercise any right, power or remedy provided in the Plan, including a delay or failure to deny a claim, that shall not waive Moda Health's rights to enforce the provisions of the Plan.

8.10 GROUP IS THE AGENT

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

8.11 GOVERNING LAW

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

8.12 WHERE ANY LEGAL ACTION MUST BE FILED

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

8.13 TIME LIMITS FOR FILING A LAWSUIT

Any legal action arising out of, or related to, the Plan and filed against Moda Health by a member or any third party, must be filed in court no more than 3 years after the time the claim was filed (see section 7.1.1). All internal levels of appeal under the Plan must be exhausted before filing a legal action in court.

8.14 EVALUATION OF NEW TECHNOLOGY

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

SECTION 9. CONTINUATION OF VISION COVERAGE

The following sections on continuation of coverage may apply. Members should check with the Group to find out if they qualify for this coverage. Both subscribers and their dependents should read the following sections carefully.

9.1 OREGON CONTINUATION FOR SPOUSES & DOMESTIC PARTNERS AGE 55 AND OVER

9.1.1 Introduction

55+ Oregon Continuation only applies to employers with 20 or more employees. Moda Health will provide 55+ Oregon Continuation coverage to those members who elect it, subject to the following conditions:

a. Moda Health will offer no greater rights than Oregon law requires
b. Moda Health will not provide 55+ Oregon Continuation coverage for members who do not comply with the requirements outlined below
c. If the Group or its designated third party administrator fails to notify the eligible spouse or domestic partner of their continuation rights, premiums shall be waived from the date the notice was required until the date notice is received by the spouse or domestic partner. The Group shall be responsible for such premiums.

Note: In section 9.1 the term “domestic partner” refers only to a registered domestic partner, as defined in Section 11.

9.1.2 Eligibility

The spouse or domestic partner of the subscriber may elect 55+ Oregon Continuation coverage for himself or herself and any enrolled dependents if the following requirements are met:

a. Coverage is lost because of the death of the subscriber, dissolution of marriage or domestic partnership with the subscriber, or legal separation from the subscriber
b. The spouse or domestic partner is 55 years of age or older at the time of such event
c. The spouse or domestic partner is not eligible for Medicare

9.1.3 Notice & Election Requirements

Notice of Divorce, Dissolution, or Legal Separation. Within 60 days of legal separation or the entry of a judgment of dissolution of marriage or domestic partnership, a member who is eligible for 55+ Oregon Continuation and seeks such coverage shall give the Group or its designated third party administrator written notice of the legal separation or dissolution. The notice shall include his or her mailing address.

Notice of Death. Within 30 days of the death of the subscriber, the Group shall give the designated third party administrator, if any, written notice of the death and the mailing address of the eligible surviving spouse or domestic partner.

Election Notice. Within 14 days of receipt of the above notice (or within 44 days of the death of the subscriber if there is no third party administrator), the Group or its designated third party administrator shall provide notice to the surviving, legally separated or divorced spouse or

domestic partner that coverage can be continued, along with an election form. If the Group or its designated third party administrator does not provide this election notice within the required timeframe, premiums shall be waived until the date notice is received.

Election. The surviving, legally separated or divorced spouse or domestic partner must return the election form within 60 days after the form is mailed. If the election is not made within 60 days of the notification, the member will lose the right to continued benefits under this section.

9.1.4 Premiums

Monthly premiums for 55+ Oregon Continuation are limited to 102% of the premiums paid by a current subscriber. The first premium shall be paid by the surviving, legally separated or divorced spouse or domestic partner to the Group or its designated third party administrator within 45 days of the date of election. All remaining monthly premiums must be paid within 30 days of the premium due date.

9.1.5 When Coverage Ends

55+ Oregon Continuation will end on the earliest of any of the following events:

a. Failure to pay premiums when due, including any grace period allowed by the Plan
b. The date the Plan ends, unless a different group policy is made available to members
c. The date the member becomes insured under any other group health plan that includes vision coverage
d. The date the member remarries or registers another domestic partnership
e. The date the member becomes eligible for Medicare

9.2 COBRA CONTINUATION COVERAGE

9.2.1 Introduction

COBRA only applies to employers with 20 or more employees on 50% of the typical business days in the prior calendar year. Certain church plans are exempted from COBRA. Moda Health will provide COBRA continuation coverage to members who have experienced a qualifying event and elect coverage under COBRA, subject to the following conditions:

a. Moda Health will offer no greater COBRA rights than the COBRA statute requires
b. Moda Health will not provide COBRA coverage for those members who do not comply with the requirements outlined below
c. Moda Health will not provide COBRA coverage if the COBRA Administrator does not provide the required COBRA notices within the statutory time periods, or if the COBRA Administrator otherwise does not comply with any of the requirements outlined below
d. Moda Health will not provide a disability extension if the COBRA Administrator does not notify Moda Health within 60 days of its receipt of a disability extension notice from a member

For purposes of section 9.2, COBRA Administrator means either the Group or a third party administrator delegated by the Group to handle COBRA administration.

9.2.2 Qualifying Events

Subscriber. A subscriber may elect continuation coverage if coverage is lost because of

termination of employment (other than termination for gross misconduct) or a reduction in hours.

Spouse. The spouse of a subscriber has the right to continuation coverage if coverage is lost for any of the following qualifying events:

a. Death of the subscriber
b. Termination of the subscriber's employment (for reasons other than gross misconduct) or reduction in the subscriber's hours of employment with the Group
c. Divorce or legal separation from the subscriber
d. Subscriber becomes entitled to Medicare

(If it can be established that a subscriber has eliminated coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the COBRA Administrator within 60 days of the divorce or legal separation, COBRA coverage may be available for the period after the divorce or legal separation.)

Children. A child of a subscriber has the right to continuation coverage if coverage is lost for any of the following qualifying events:

a. Death of the subscriber
b. Termination of the subscriber's employment (for reasons other than gross misconduct) or reduction in a subscriber's hours of employment with the Group
c. Parents' divorce or legal separation
d. Subscriber becomes entitled to Medicare
e. Child ceases to be a "child" under the Plan

Domestic Partners. A subscriber, who at the time of the qualifying event was covering his or her domestic partner under the Plan, can elect COBRA continuation coverage that includes continuing coverage for the domestic partner. A domestic partner who is covered under the Plan by the subscriber is not an eligible member under COBRA and, therefore, does not have an independent election right under COBRA. This also means that the domestic partner's coverage ends immediately when the subscriber's COBRA coverage terminates (for example, due to the subscriber's death or because the subscriber becomes covered under another plan).

Retirees. If the subscriber's former employer files a Chapter 11 bankruptcy proceeding, this may be a qualifying event for the retiree who loses coverage as a result, and for his or her covered dependents.

9.2.3 Continuation Upon Retirement

Retired employees (retirees) and their dependents are eligible to continue coverage subject to the following:

a. The retiree must apply for continued coverage within 60 days after retirement.
b. The retiree must have been continuously covered under the Plan for at least twenty-four (24) months.

c. The retiree must be receiving benefits for PERS (Public Employee Retirement System) or from a similar retirement plan offered by the Group.

The retiree must enroll in the same benefit plan option they had as an active employee and may not transfer to another plan option offered by the Group. If the Group changes plan benefits, the retiree's plan benefits will change accordingly.

Except for newly acquired dependents due to marriage, registration of domestic partnership, birth, or adoption, only the retiree's dependents who were covered at the time of retirement may continue coverage under this provision. The retiree may add a new spouse, domestic partner, or other newly acquired dependent after retirement if family coverage is available. When a premium increase is required, a completed enrollment application must be submitted within 31 days of the date of marriage, registration of the domestic partnership, birth, or adoption.

Coverage under this provision will end for the subscriber according to the following:

a. When the full premium is not paid or when the coverage is voluntarily terminated, the retiree's coverage will end on the last day of the month for which premium was paid.
b. When the retiree becomes eligible for federal Medicare coverage, his or her coverage will end on the last day of the month preceding Medicare eligibility.
c. When the Group's policy is terminated, the retiree's coverage will end on the date of termination.

Coverage under this provision will end for dependents according to the following:

a. When the full premium for the dependent is not paid or when the dependent's coverage is voluntarily terminated by the retiree or the dependent, coverage will end on the last day of the month for which premium was paid.
b. When the retiree's dependent becomes eligible for federal Medicare coverage, coverage will end on the last day of the month preceding Medicare eligibility.
c. When the retiree dies, divorces, or dissolves a domestic partnership, the dependent's coverage will end on the last day of the month following the death, divorce, or dissolution of the domestic partnership.
d. When the dependent child is no longer considered a dependent under the Plan, the dependent's coverage will end on the last day of the month of their eligibility.
e. When the Group's policy is terminated, the dependent's coverage will end on the date of the termination.

9.2.4 Other Coverage

The right to elect continuation coverage shall be available to persons who are entitled to Medicare or are covered under another group health plan at the time of the election.

9.2.5 Notice & Election Requirements

Qualifying Event Notice. A dependent member's coverage ends as of the last day of the month in which a divorce or legal separation occurs (spouse's coverage is lost) or a child loses dependent status under the Plan (child loses coverage). Under COBRA, the subscriber or a family member has the responsibility to notify the COBRA Administrator if one of these events occurs by mailing or hand-delivering a written notice to the COBRA Administrator. The notice must include the

following: 1) the name of the Group; 2) the name and social security number of the affected members; 3) the event (e.g. divorce); and 4) the date the event occurred. Notice must be given no later than 60 days after the loss of coverage under the Plan. If notice of the event is not given on time, continuation coverage will not be available.

Election Notice. Members will be notified of their right to continuation coverage within 14 days after the COBRA Administrator receives a timely qualifying event notice.

Otherwise, members will be notified by the COBRA Administrator of the right to elect COBRA continuation coverage within 44 days of any of the following events that result in a loss of coverage: the subscriber's termination of employment (other than for gross misconduct), reduction in hours, death of the subscriber, the subscriber's becoming entitled to Medicare, or the Group files for Chapter 11 reorganization.

Election. A member must elect continuation coverage within 60 days after plan coverage ends, or, if later, 60 days after the COBRA Administrator sends notice of the right to elect continuation coverage to the members. If continuation coverage is not elected, group vision coverage will end.

A subscriber or the spouse may elect continuation coverage for eligible family members. Each family member also has an independent right to elect COBRA coverage. This means that a spouse or child may elect continuation coverage even if the subscriber does not.

If COBRA is elected, the Group will provide the same coverage as is available to similarly situated members under the Plan.

9.2.6 COBRA Premiums

Members are responsible for all premiums for continuation coverage. Due to the 60-day election period, it is likely that retroactive premiums will be owed for the months between when regular coverage ended and the first payment date. These premiums must be paid in a lump sum at the first payment. The first payment for continuation coverage is due within 45 days after a member provides notice of electing coverage (this is the date the election notice is postmarked, if mailed, or the date the election notice is received by the COBRA Administrator, if hand-delivered). Subsequent payments are due on the first day of the month. There will be a grace period of 30 days to pay the premiums. Moda Health will not send a bill for any payments due. The member is responsible for paying the applicable premiums when due, otherwise continuation coverage will end and may not be reinstated. The premium rate may include a 2% add-on to cover administrative expenses.

9.2.7 Length of Continuation Coverage

18-Month Continuation Period. When coverage is lost due to end of employment or a reduction of hours of employment, coverage generally may be continued for up to a total of 18 months.

36-Month Continuation Period. In the case of losses of coverage due to a subscriber's death, divorce or legal separation, or a child ceasing to be a dependent under the terms of the Plan, coverage under the Plan may be continued for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the subscriber's hours of employment, and the subscriber became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for members (other than the subscriber) who lose

coverage as a result of the qualifying event can last up to 36 months after the date of Medicare entitlement. This COBRA coverage period is available only if the subscriber becomes entitled to Medicare within 18 months before the termination or reduction of hours.

Extended Period. In the case of loss of coverage due to the bankruptcy of the Group, coverage for the retired subscriber may be continued up to his or her death. Coverage for each dependent may be continued up to the dependent's death or 36 months after the retired subscriber's death, whichever is earlier.

9.2.8 Extending the Length of COBRA Coverage

An extension of the maximum period of coverage may be available if a member is disabled or a second qualifying event occurs. The COBRA Administrator must be notified of a disability or a second qualifying event in order to extend the period of COBRA coverage. If the member does not provide notice of a disability or second qualifying event, he or she will lose the right to extend the period of COBRA coverage.

Disability. If any of the members is determined by the Social Security Administration to be disabled, the maximum COBRA coverage period that results from a subscriber's termination of employment or reduction of hours may be extended to a total of up to 29 months. The disability must have started before the 61st day after the subscriber's termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months). Each member who has elected COBRA coverage will be entitled to the disability extension if one of them qualifies.

The disability extension is available only if the Social Security Administration determination is within the 18-month period following the subscriber's termination of employment or reduction of hours. The member must provide a copy of the Social Security Administration's determination of disability to the COBRA Administrator within 60 days after the latest of:

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

If the notice is not provided within this timeframe, then there will be no disability extension of COBRA coverage. The premiums for COBRA coverage may increase after the 18th month of coverage to 150% of the premium.

If determined by the Social Security Administration to no longer be disabled, the member must notify the COBRA Administrator of that fact within 30 days after the Social Security Administration's determination.

Second Qualifying Event. An extension of coverage will be available to spouses and children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the subscriber's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months from the date of the first qualifying event. Second qualifying events may include the death of a subscriber, divorce or legal separation from the subscriber, or a child ceasing to be eligible for coverage as a dependent under the Plan. These

events can be a second qualifying event only if they would have caused the member to lose coverage under the Plan if the first qualifying event had not occurred. (This extension is not available under the Plan when a subscriber becomes entitled to Medicare after his or her termination of employment or reduction of hours.)

This extension is only available only if the COBRA Administrator is notified in writing of the second qualifying event within 60 days after the date of the event. If this notice is not provided to the COBRA Administrator during the 60-day notice period, then there will be no extension of COBRA coverage due to a second qualifying event.

Note: Longer continuation coverage may be available under Oregon law for a subscriber's spouse or domestic partner age 55 and older who loses coverage due to the subscriber's death, or due to legal separation or dissolution of marriage or domestic partnership (see section 9.1).

9.2.9 Special Enrollment & Open Enrollment

Members under continuation coverage have the same rights as similarly situated members who are not enrolled in COBRA. A member may add children, spouses or domestic partners as covered dependents in accordance with the Plan's eligibility and enrollment rules (see Section 5 and Section 6), including HIPAA special enrollment. If non-COBRA members can change plans at open enrollment, COBRA members may also change plans at open enrollment.

9.2.10 When Continuation Coverage Ends

COBRA coverage will end earlier than the maximum period if:

a. Any required premiums are not paid in full on time
b. A member becomes covered under another group health plan
c. A member becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA. (However, if the qualifying event is the Group's bankruptcy, the member will not lose COBRA because of entitlement to Medicare benefits)
d. The Group ceases to provide any group vision plan for its employees
e. During a disability extension period (see section 9.2.8), the disabled member is determined by the Social Security Administration to be no longer disabled (COBRA coverage for all members, not just the disabled member, will end)

COBRA coverage may also be canceled for any reason the Plan would terminate coverage of a member not receiving COBRA coverage (such as fraud).

Questions about COBRA should be directed to the COBRA Administrator. The COBRA Administrator should be informed of any address changes.

9.3 UNIFORMED SERVICES EMPLOYMENT & REEMPLOYMENT RIGHTS ACT (USERRA)

Coverage will end if a subscriber is called to active duty by any of the armed forces of the United States of America. However, if a subscriber asks to continue coverage under USERRA, coverage can be continued for up to 24 months or the period of uniformed service leave, whichever is shortest, if the subscriber pays any required contributions toward the cost of the coverage during the leave. If the leave is 30 days or less, the contribution rate will be the same as for active members. If the leave is longer than 30 days, the required contribution will not exceed 102% of

the cost of coverage.

If a subscriber does not elect continuation coverage under USERRA or if continuation coverage is terminated or exhausted, coverage will be reinstated on the first day he or she returns to active employment with the Group if released under honorable conditions, but only if he or she returns to active employment:

a. On the first full business day following completion of military service for a leave of 30 days or less
b. Within 14 days of completing military service for a leave of 31 to 180 days
c. Within 90 days of completing military service for a leave of more than 180 days

Regardless of the length of the leave, a reasonable amount of travel time or recovery time for a medical condition determined by the Veteran's Administration (VA) to be service connected will be allowed.

When coverage under the Plan is reinstated, all plan provisions and limitations will apply to the extent that they would have applied if the subscriber had not taken military leave and coverage had been continuous under the Plan. There will be no additional eligibility waiting period. (This waiver of limitations does not provide coverage for any medical condition caused or aggravated by military service, as determined by the VA. Complete information regarding rights under USERRA is available from the Group).

9.4 FAMILY & MEDICAL LEAVE

If the Group grants a leave of absence under state or federal family and medical leave laws, the following rules will apply:

a. Affected members will remain eligible for coverage during a family and medical leave.
b. If members elect not to remain enrolled during a family and medical leave, they will be eligible to re-enroll in the Plan on the date the subscriber returns from leave. To re-enroll, a complete and signed application must be submitted within 60 days of the return to work. All of the terms and conditions of the Plan will resume at the time of re-enrollment as if there had been no lapse in coverage. Any group eligibility waiting period under the Plan will not have to be reserved.
c. A subscriber's rights under family and medical leave will be governed by applicable state or federal statute and regulations.

9.5 STRIKE OR LOCKOUT

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

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

a. Fewer than 75% of those normally enrolled choose to continue their coverage
b. A subscriber accepts full-time employment with another employer
c. A subscriber otherwise loses eligibility under the Plan

SECTION 10. ERISA DUTIES

Subscribers are entitled to certain rights and protections if the Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA). Members should ask the Group if this section is applicable.

10.1 Plan Administrator as Defined Under ERISA

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

10.2 Information about the Plan and Benefits

Subscribers may examine, without charge, at the Group's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, collective bargaining agreements (if applicable), updated summary plan description, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (if any). This information can be obtained by written request. The Group may make a reasonable charge for the copies.

Subscribers are entitled to receive a summary of the Plan's annual financial report, if any is required by ERISA. The Group is required by law to furnish each subscriber with a copy of this summary annual report.

10.3 Continuation of Group Vision Coverage

Subscribers are entitled to continue vision care coverage for themselves or their dependents if coverage under the Plan is lost as a result of a qualifying event. Members may have to pay for such coverage. Members should review this handbook and the documents governing the Plan regarding the rules governing continuation coverage rights.

10.4 Prudent Actions by Plan Fiduciaries

In addition to creating rights for members, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of members. No one, including the employer or any other person, may fire or discriminate against a subscriber in any way to prevent him or her from obtaining a benefit or exercising rights under ERISA.

10.5 Enforcement of Rights

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

Under ERISA, there are steps members can take to enforce these rights. For instance, if a copy of plan documents or the latest annual report from the Group is requested and not received within 30 days, a member may file suit in federal court. In such a case, the court may require the Group to provide the materials and pay the member up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Group. If a claim for benefits is denied or no action is taken, in whole or in part, a member may file suit in state or federal court after exhausting the appeal process required by the Plan (see section 7.2). In addition, a member who disagrees with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order may file suit in federal court.

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

10.6 Assistance with Questions

For questions about this section or a member's rights under ERISA, or for assistance in obtaining documents from the Group, members should contact the Employee Benefits Security Administration: Seattle District Office, 300 Fifth Avenue, Suite 1110, Seattle, Washington, 98104, telephone 206-757-6781, or Office of Outreach, Education and Assistance, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210, telephone 866-444-3272. Information and assistance is also available through their website: dol.gov/agencies/ebsa Members may obtain publications about their rights and responsibilities under ERISA by calling the Office of Outreach, Education and Assistance.

SECTION 11. DEFINITIONS

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

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

Coinsurance means the percentages of covered expenses to be paid by a member.

Copay or Copayment means the fixed dollar amounts to be paid by a member to a vision provider when receiving a covered service.

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.

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

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

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

a. **Registered Domestic Partner** means a person joined with the subscriber in a partnership that has been registered under the laws of any federal, state or local government.
b. **Unregistered Domestic Partner** means a person who has entered into a partnership with the subscriber that meets the criteria in the Group's affidavit of domestic partnership for a minimum of 6 months.

Eligible Employee means any employee or former employee who meets the eligibility requirements to be enrolled on the Plan (see section 5.1).

Enroll means to become covered for benefits under the Plan (that is, when coverage becomes effective) without regard to when the person may have completed or filed any forms that are required in order to become covered. For this purpose, a person who has vision coverage is enrolled in the Plan regardless of whether the person elects coverage, the person is a dependent who becomes covered as a result of an election by a subscriber, or the person becomes covered without an election.

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

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

a. Involve a treatment for which scientific or medical assessment has not been completed, or the effectiveness of the treatment has not been generally established

b. Are available in the United States only as part of clinical trial or research program for the illness or condition being treated
c. Are not provided by an accredited provider within the United States or are provided by one that has not demonstrated medical proficiency in the rendering of the service or supplies
d. Are not recognized by the medical community in the service area in which they are received
e. Involve a treatment for which the approval of one or more government agencies is required, but has not been obtained at the time the services and supplies are rendered or are to be rendered

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

In-Network refers to providers that are contracted under Moda Health to provide vision care to members.

Medical Condition means any physical or mental condition, including one resulting from illness, injury (whether or not the injury is accidental), pregnancy, or congenital malformation. Genetic information in and of itself is not a condition.

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

a. It is consistent with the symptoms or diagnosis of a member's condition and appropriate considering the potential benefit and harm to the patient
b. The service, supply or intervention is known to be effective in improving vision outcomes
c. The service, supply or intervention is cost effective compared to the alternative intervention, including no intervention

The fact that a provider prescribes, orders, recommends, or approves a service or supply does not, of itself, make the service medically necessary or a covered service. Claims processing may be delayed if proof of medical necessity is required but not provided by the vision care provider.

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

More information about medical necessity can be found in Exclusions (Section 4).

Member means a subscriber or dependent of a subscriber who is enrolled for coverage under the terms of the Plan.

Moda Health refers to Moda Health Plan, Inc.

Network means a group of vision providers who contract to provide vision care to members at negotiated rates. Such groups are called Preferred Provider Organizations (PPOs), and provide in-network services in their specific service areas. Covered vision expenses will be paid at a higher rate when an in-network vision provider is used.

Out-of-Network refers to vision providers that are not contracted under Moda Health to charge discounted rates to members.

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

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

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

Subscriber means any employee or former employee who is enrolled in the Plan.

Vision Provider means any of the following state-licensed professionals, when providing medically necessary services or supplies within the scope of their license. In all cases, the services or supplies must be covered under the Plan to be eligible for benefits.

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

The term vision provider does not include any class of provider not named above, and no benefits of the Plan will be paid for their services.

Waiting Period means the period that must pass before a person is eligible to enroll for benefits under the terms of the Plan.

Moda does not discriminate

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

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

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

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

888-217-2363 (TDD/TTY 711)

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

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

Dave Nesseler-Cass coordinates our nondiscrimination work:

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

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

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

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

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

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

Health plans in Oregon and Alaska provided by Moda Health Plan, Inc. Dental plans in Oregon provided by Oregon Dental Service, dba Delta Dental Plan of Oregon. Dental plans in Alaska provided by Delta Dental of Alaska. 39969758 (8/18)

moda HEALTH

DELTA DENTAL
Delta Dental of Oregon & Alaska

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

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

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

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

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

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

بولتے ہیں تو لسانی (URDU) توجہ دیں: اگر آپ اردو اعانت آپ کے لیے بلا معاوضہ دستیاب ہے۔ پر کال کریں 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).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

modahealth.com

moda HEALTH

DELTA DENTAL

Delta Dental of Oregon & Alaska

For help, call us directly at 888-217-2363.
(En Español: 888-786-7461)

P.O. Box 40384
Portland, OR 97240

ModaORVisBk 1-1-2020 (10000128)