OREGON EDUCATORS
OEBB
BENEFIT BOARD

Group Vision Plan
OEBB

Vision Plan 1
Effective Date: October 1, 2015

moda

modahealth.com

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

Moda Health reserves the right to monitor telephone conversations and e-mail communications between its employees and its customers for legitimate business purposes as determined by Moda Health. The monitoring is to ensure the quality and accuracy of the service provided by employees of Moda Health to their customers.

This handbook may be changed or replaced at any time, by OEBB 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 OEBB's policy with Moda Health. This handbook may not contain every plan provision.

SECTION 2 MEMBER RESOURCES

Moda Health Website (log in to myModa)
www.modahealth.com/oebb

Medical Customer Service Department
Portland 503-265-2909; Toll-Free 866-923-0409;
En Español 503-265-2961; Llamado gratis 888-786-7461

Telecommunications Relay Service for the hearing impaired
711

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

2.1 MEMBERSHIP CARD

After enrolling, members will receive identification (ID) cards which will include the group and identification numbers, and the applicable network name. Members will need to present their cards each time they receive services from in-network vision providers.

Members may go to myModa or contact Customer Service for replacement of a lost ID card.

During the first appointment, members should tell their vision provider they have vision benefits through Moda Health. The member will need to provide their subscriber identification number and Moda Health Group number. These numbers are located on the I.D. card.

2.2 NETWORKS

Vision benefits can be maximized by using an in-network vision provider. Members may choose an in-network vision provider from the network medical directory, which is available on myModa under “Find Care” or by contacting Customer Service Department for assistance.

For all members:
Connexus for residents in Oregon, Idaho, southern Washington and northern California

For subscribers, eligible spouse, domestic partner, or child(ren) if subscribers reside outside the Connexus service area:
First Choice Health Network (FCH) for residents in Washington (excluding southwest Washington)
Health InfoNet (HIN) for residents in Montana
Private Healthcare Systems (PHCS) for residents in all other states.

SECTION 3 DEFINITIONS

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

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

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

Contracted fee means the amount an in-network provider has agreed to accept as the covered charge.

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.

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 spouse, domestic partner or child 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:

a. Are not provided by a provider within the United States or are provided by one that has not demonstrated medical proficiency in the provision of the service or supplies
b. Are not recognized by the medical community in the service area in which they are received
c. 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
d. Involve a treatment for which scientific or medical assessment has not been completed, or the effectiveness of the treatment has not been generally established

e. Are available in the United States only as part of clinical trial or research program for the illness or condition being treated

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

In-Network refers to vision providers that are contracted under Moda Health to provide 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 is not considered a condition.

Medically Necessary means those services and supplies that are required for diagnosis or treatment of a medical condition and are:

a. Appropriate and consistent with the symptoms or diagnosis of the member's condition
b. Established as the standard treatment by the medical community in the service area in which they are received
c. Not primarily for the convenience of the member or a provider
d. The least costly of the alternative supplies or levels of service that can be safely provided to the member.

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. More information regarding medical necessity can be found in section 5.

Member means and includes the subscriber, spouse, eligible domestic partner or child.

Moda Health refers to Moda Health Plan, Inc.

Network means a group of vision providers who contract to provide vision care to members. Such groups are called Preferred Provider Organizations (PPOs), and provide in-network services in their specific service areas.

Out-of-Network refers to vision providers that have not contracted under Moda Health to provide benefits to members.

Plan is the vision benefit plan sponsored by OEBB and insured under the terms of the policy between OEBB and Moda Health based on the member handbook.

Plan Year means the 12-month period or portion thereof commencing October 1st of any calendar year and ending September 30th of the subsequent calendar year

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

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

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

Vision Provider means any of the following, 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. A licensed ophthalmologist
b. A licensed optician
c. A licensed optometrist
d. A hardware provider

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.

SECTION 4 BENEFIT DESCRIPTION

The Plan pays up to a maximum of $250 every plan year. A routine eye exam and one pair of corrective lenses for eyeglasses are covered every plan year. One pair of frames is covered every plan year for members under age 17 and every 2 plan years for members 17 years and older. Late enrollees have a 12-month waiting period for lenses and frames, but are eligible for a routine eye exam (for details on Late Enrollment see section 7.5).

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

4.1 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 2.2). Members will maximize their benefits by using these providers for vision services.

4.2 COVERED SERVICES AND SUPPLIES

The following services are covered:

a. One complete eye exam, including the charge for refraction
b. One pair of frames for corrective lenses
c. Corrective lenses for either eyeglasses or contact lenses

Covered lenses include:

i. Single vision
ii. Multifocal (bifocal)
iii. Trifocal, Progressive, , Lenticular
iv. Standard polycarbonate lenses
v. Contact lenses (disposable or conventional)
vi. Oversized
vii. Tinted, any color

SECTION 5 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. In addition, any direct complication or consequence that arises from these exclusions will not be covered, unless services are otherwise required by law.

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

Experimental or Investigational Procedures
Including expenses incidental to or incurred as a direct consequence of such procedures.

Illegal Acts, Riot or Rebellion
Services or supplies for treatment of a medical condition caused by or arising out of a member's voluntary participation in a riot, armed invasion or aggression, insurrection or rebellion or arising directly from an illegal act.

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.

Missed Appointments

Reports and Records
Including charges for the completion of claim forms.

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.

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

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. those 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 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

Surgery to Alter Refractive Character of the Eye
Any procedure that alters the refractive character of the eye, the purpose of which is to cure or reduce myopia, hyperopia, or astigmatism. Includes reversals or revisions of any such procedures and any complications of these procedures.

Taxes

Third-party Liability Claims
Services and supplies for treatment of a medical condition 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 8.3.2).

Treatment after Coverage Terminates

Treatment Not Medically Necessary
Including services or supplies that:

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

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

Treatment Prior to Enrollment

Vision Care Related Procedures and Services
Including charges for:

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

Work Related Conditions
Treatment of a 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 6 ELIGIBILITY

The Plan's eligibility rules are outlined in the Oregon Administrative Rules under OAR 111-015-0001. The date a person becomes eligible may be different than the date coverage begins. More specific information can be found under the Enrollment section (see section 7).

6.1 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 7 ENROLLMENT

7.1 NEWLY-HIRED AND NEWLY-ELIGIBLE ACTIVE ELIGIBLE EMPLOYEES

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

7.2 QUALIFIED STATUS CHANGES

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

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

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

The special enrollment rights as described above apply:

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

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

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

7.3 EFFECTIVE DATES

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

7.4 OPEN ENROLLMENT

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

7.5 LATE ENROLLMENT

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

7.6 RETURNING TO ACTIVE ELIGIBLE EMPLOYEE STATUS

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

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

7.7 REMOVING AN INELIGIBLE INDIVIDUAL FROM BENEFIT PLANS

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

7.8 WHEN COVERAGE ENDS

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

7.8.1 Group Plan Termination

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

7.8.2 Termination by Subscriber

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

7.8.3 Rescission

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

7.8.4 Continuing Coverage

Additional information is in Continuation of Vision Coverage (see section 11).

7.9 DECLINATION OF COVERAGE

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

SECTION 8 CLAIMS ADMINISTRATION & PAYMENT

8.1 SUBMISSION AND PAYMENT OF CLAIMS

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.

8.1.1 Claim Submission

A vision provider will often bill charges directly to Moda Health. When the member is billed by the vision provider directly, he or she should send a copy of the bill to Moda Health at the address listed below 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 services and charges with corresponding American Medical Association CPT and/or Centers for Medicare and Medicaid HCPCS codes

Moda Health
Attn: Medical Claims Department
P.O. Box 40384
Portland, Oregon 97240

If the treatment is for an accidental injury, a statement explaining the date, time, place, and circumstances of the accident must be included with the bill.

8.1.2 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 9.1.

8.1.3 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.

8.2 DISPUTE RESOLUTIONS

8.2.1 Definitions

For the purposes of section 8.2 the following definitions apply:

Adverse Benefit Determination means a written notice from Moda Health, in the form of a letter or an Explanation of Benefits (EOB), of any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including one based on a determination of a member's eligibility to participate in the Plan and one resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not necessary and customary by the standards of generally accepted practice for the prevention or treatment of disease or accidental injury.

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

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

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

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

Utilization Review means a system of reviewing the necessity, appropriateness, or quality of services and supplies using specified guidelines, including the application of practice guidelines, prior authorization of procedures, and retrospective review. An adverse benefit determination that the item or service is not necessary or appropriate, is investigational or experimental, or in which the decision as to whether a benefit is covered involved a professional judgment is a utilization review decision.

8.2.2 Time Limit for Submitting Appeals

A member has **180 days** from the date of an adverse benefit determination to submit an initial written appeal. If an appeal is not submitted within the timeframes outlined in this section, the rights to the appeals process will be lost.

8.2.3 The Review Process

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

The timelines addressed in the sections below do not apply when the member does not reasonably cooperate, or circumstances beyond the control of either party prevents that party from complying with the standards set (but only if the party who is unable to comply gives notice of the specific circumstances to the other party when the circumstances arise).

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.

8.2.4 First-level Appeals

Before filing an appeal, it may be possible to resolve a dispute with a phone call to Customer Service. Otherwise, an appeal must be submitted in writing to Moda Health. If necessary, Customer Service can provide assistance filing an appeal. Written comments, documents, records, and other information relating to the claim for benefits may be submitted. Moda Health will acknowledge receipt of the written appeal within 7 days and conduct an investigation by persons who were not previously involved in the original determination. The investigation will be completed within 30 days of receipt of the appeal.

When an investigation has been completed, Moda Health will send a written notice of the decision to the member, including the basis for the decision. If applicable, the notice will include information on the right to a second-level appeal.

8.2.5 Second-level Appeals

A member who disagrees with the decision regarding the first-level appeal may request 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 determinations. The member will have the option to submit written comments, documents, records and other information related to the case that were not previously submitted.

Investigations and responses to a second level appeal will follow the same timelines as those outlined in section 8.2.4. Moda Health will notify the member in writing of the decision, and the basis for the decision.

8.3 BENEFITS AVAILABLE FROM OTHER SOURCES

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

8.3.1 Coordination of Benefits (COB)

This provision applies when a member has vision coverage under more than one plan. A complete explanation of COB is in section 10.

8.3.2 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 a medical condition for which such costs were paid by Moda Health. of the Plan does not cover benefits for which a third party may be legally liable. Because recovery from a third party may be difficult and take a long time, as a service to the member, Moda Health will pay a member's expenses based on the understanding and agreement that Moda Health is entitled to be reimbursed in full from any recovery the member may receive for any benefits it paid that are or may be recoverable from a third party or other source, no matter how it is characterized.

The member agrees that Moda Health has the rights described in section 8.3.2. 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. Moda Health has the sole discretion to interpret and construe these recovery and subrogation provisions.

8.3.2.1 Definitions:

For purposes of section 8.3.2, 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 to Moda Health by a provider to or on behalf of a member are considered requests for payment of benefits by the member.

Recovery Funds means any amount recovered from a third party.

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 as an action) by or on behalf of a member, regardless of how the claims or damages or recovery funds are characterized. (For example, a member who has received payment of vision expenses from Moda Health may file a third party claim, but only seek the recovery of non-economic damages. In that case, Moda Health is still entitled to recover benefits as described in section 8.3.2.)

8.3.2.2 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 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.

8.3.2.3 Right of Recovery

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

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 medical condition

b. Moda Health is entitled to receive the amount of benefits it has paid for vision services related to a medical condition out of any settlement or judgment that results from exercising the right of recovery against the third party. This is so whether or not the third party admits liability or claims that the member is also at fault. In addition, Moda Health is entitled to receive the amount of benefits 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 from the first dollars 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
f. In third-party claims involving the use or operation of a motor vehicle, Moda Health, at its option, may seek reimbursement under the Personal Injury Protection statutes of the state of Oregon, including ORS 742.534, ORS 742.536, or ORS 742.538 or under other applicable state law.

8.3.2.5 Additional Third Party Liability Provisions

In connection with Moda Health's rights as discussed in the above sections, members shall do one or more of 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. The Plan will not be required to pay benefits until the agreement is properly signed and returned.
    ii. Providing any information to Moda Health relevant to the application of the provisions of section 8.3.2, 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 aid by Moda Health from the third party.

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

d. The member agrees that Moda Health may notify any third party, or third party's representatives or insurers of its recovery rights described in section 8.3.2

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 8.3.2

f. Section 8.3.2 applies to any member for whom advance payment of benefits is made by Moda Health whether or not the event giving rise to the member's injuries occurred before the member became covered by Moda Health

g. If the member continues to receive vision treatment for a medical 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. Moda Health may notify medical 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

SECTION 9 COORDINATION OF BENEFITS

Coordination of Benefits (COB) occurs when a member has vision coverage under more than one plan.

9.1 DEFINITIONS

For purposes of section 9, 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 two parts and COB rules apply to only one of the two, each of the parts is treated as a separate plan.

Complying plan is a plan that complies with these COB rules.

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

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

An **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 rather than 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 failed to comply with the plan provisions 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 two 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 two 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 or services 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 or services 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.

A **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.

9.2 HOW COB WORKS

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.

The p**rimary 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 Moda Health 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

9.3 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, for example, an employee, member of an organization, subscriber, 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, registered domestic partners, 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 Coverage by Parent and Spouse.** For a dependent child covered under the plans of both a parent and a spouse, the length of coverage provision below shall determine the order of benefits. If coverage under either or both parents' plans and the spouse'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, that is, 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 had it been the primary plan

9.4 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.

SECTION 10 MISCELLANEOUS PROVISIONS

10.1 RIGHT TO COLLECT AND 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.

10.2 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 503-243-4492.

10.3 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 upon a member's written request.

10.4 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.

10.5 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.

10.6 CONTRACT PROVISIONS

OEBB's policy with Moda Health 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

10.7 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 or damages connected with injuries a member suffers while receiving vision services or supplies.

10.8 WARRANTIES

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

10.9 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 denying a claim, that shall not waive Moda Health's rights to enforce the provisions of the Plan.

10.10 GROUP IS THE AGENT

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

10.11 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.

10.12 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.

10.13 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 8.1). All internal levels of appeal under the Plan must be exhausted before filing a legal action in court.

10.13 EVALUATION OF NEW TECHNOLOGY

Moda Health develops medical necessity criteria for new technologies and new use of current technologies. The technology 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 11 CONTINUATION OF VISION COVERAGE

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

11.1 FAMILY AND MEDICAL LEAVE

If the participating organization 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 family and medical 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 re-served.
c. A subscriber's rights under family and medical leave will be governed by applicable state or federal statute and regulations.

11.2 LEAVE OF ABSENCE

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

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

11.3 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 six months. The subscriber must pay the full premiums, including any part usually paid by the participating organization, 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

11.4 RETIREES

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

11.5 OREGON CONTINUATION FOR SPOUSES AND DOMESTIC PARTNERS AGE 55 AND OVER

11.5.1 Introduction

Moda Health will provide 55+ Oregon Continuation coverage to those members who elect it.

Other than the inclusion of domestic partners, Moda Health will offer no greater rights than ORS 743.600 to 743.602 requires

11.5.2 Eligibility

a. If a spouse or domestic partner is 55 or older at the time coverage is lost due to death of the subscriber, divorce or legal separation, or termination of a domestic partnership, he or she may elect to continue coverage. The spouse or domestic partner cannot be eligible for Medicare.

11.5.3 Notice and Election Requirements

OEBB is responsible for providing the required election notice to a spouse or domestic partner eligible under this section. If OEBB fails to provide notices as required under statute, premiums will be waived from the date the notice was required until the date notice is received by the spouse or domestic partner. OEBB will be responsible for such premiums.

OEBB will send an election notice within 14 days of receiving notice of an election event. The eligible spouse or domestic partner must return the election form within 60 days from the date mailed, or will lose the right to elect continued coverage under this section.

An eligible spouse or domestic partner who wants to continue coverage, is responsible for providing written notice of the event to OEBB. The notice should include the event date and the eligible individual's mailing address. If notice is not submitted timely, the spouse or domestic partner will lose eligibility rights under this section.

Notice of Divorce, Dissolution, or Legal Separation. If coverage is lost due to one of these events, the spouse or domestic partner must provide notice within 60 days of the event.

Notice of Death. If coverage is lost due to the subscriber's death, the spouse or domestic partner must provide notice within 30 days of the death.

11.5.4 Premiums

The election notice will include information regarding the cost of continuation coverage and the premium due date. Premiums are limited to 102% of the premiums paid by a current subscriber.

11.5.5 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 terminates, or the date the Participating Employer terminates participation under the Plan, 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 and becomes covered under another group health plan that includes vision coverage
e. The date on which the member becomes eligible for Medicare

11.6 COBRA CONTINUATION COVERAGE

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

11.6.1 Introduction

Moda Health will provide COBRA continuation coverage to members who have experienced a qualifying event and elect coverage under COBRA.

For purposes of section 11.6, COBRA Administrator means either OEBB or a third party administrator delegated by OEBB to handle COBRA administration.

A qualified beneficiary is a person who is eligible for COBRA continuation coverage.

11.6.2 Qualifying Events

Subscriber. A subscriber may elect continuation coverage if coverage is lost because of termination of employment (other than termination for gross misconduct, which may include misrepresenting immigration status to obtain employment) 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 subscribe;
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. The subscriber becomes entitled to Medicare

Also, if a subscriber eliminates 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 date of 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 later divorce or legal separation and can establish that the coverage was eliminated earlier in anticipation of the divorce or legal separation, then 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. The subscriber becomes entitled to Medicare
e. The dependent ceases to be a "child" under the Plan

Domestic Partners. A domestic partner, who at the time of the qualifying event was covered under the Plan, can elect COBRA continuation coverage. Under the Plan, the domestic partner would have the same rights to COBRA continuation coverage as a spouse does, unless otherwise stated. Where this COBRA section refers to divorce or legal separation, termination of domestic partnership would apply for domestic partners.

11.6.3 Other Coverage

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

11.6.4 Notice and Election Requirements

Qualifying Event Notice. A dependent member's coverage terminates 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. The COBRA administrator will notify qualified beneficiaries of their right to continuation coverage after the COBRA Administrator receives a timely qualifying event notice.

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. However, each family member 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.

11.6.5 Length of Continuation Coverage

If coverage terminates due to the subscriber's employment termination or reduction in hours, COBRA continuation coverage lasts for 18 months.

Spouses, domestic partners and children who lose coverage for qualifying events other than the subscriber's loss of employment or reduction of hours, are eligible for 36 months of continued coverage.

11.6.6 Extending the Length of COBRA Coverage

If COBRA is elected, 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 fails to provide notice of a disability or second qualifying event will eliminate 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 at some time 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 COBRA Administrator is notified in writing of the Social Security Administration's determination of disability 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

A member must provide the COBRA Administrator a copy of the Social Security Administration's determination within the 18-month period following the subscriber's termination of employment or reduction of hours, and not later than 60 days after the Social Security Administration's determination was made. 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 premiums.

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. Such 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 due to a second qualifying event is available only if the COBRA Administrator is notified in writing of the second qualifying event within 60 days after the date of the second qualifying 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 who has entered into a "Declaration of Domestic Partnership" that is recognized under Oregon law 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 11.5).

11.6.7 Newborn or Adopted Child

If, during continuation coverage, a child is born to or placed for adoption with the subscriber, the child is considered an eligible member. The subscriber may elect continuation coverage for the child provided the child satisfies the otherwise applicable plan eligibility requirements (for example, age). The participating organization must be notified within 60 days of the birth or placement to obtain continuation coverage. If the participating organization is not notified in a timely fashion, the child will not be eligible for continuation coverage.

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

11.7 UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Coverage will terminate if a subscriber is called to active duty by any of the armed forces of the United States of America. However, if a subscriber requests to continue coverage under USERRA, coverage can be continued for up to 24 months or the period of uniformed service leave, whichever is shortest, provided 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 eligible 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).

For help, call us directly at 866-923-0409

(En Español: 888-786-7461)

P.O. Box 40384
Portland, OR 97204

modahealth.com