allcare medigap
1701 NE 7th
Street Grants Pass,
OR 97526
(888) 460-0185

AllCare MediGap Plan "G"

Medicare Supplement Plan G Policy issued by **AllCare Health Plan, Inc.**

This Policy of insurance supplements benefits for services that are covered by Medicare and is entered into between You, the Policyholder, and AllCare Health Plan, Inc. dba AllCare MediGap (AllCare). The terms "We," "Us", and "Our" used throughout this Policy refer to AllCare. The terms "You" and "Your" refer to the Policyholder, and the term "Policyholder" means the person enrolled for coverage under a AllCare MediGap Medicare Supplement health insurance Policy and whose name appears on the records of AllCare as the individual to whom this Policy was issued. Other important terms used in this Policy are defined in "Definitions" (Article 1) at the beginning of this Policy or where they are first used and are designated by the first letter being capitalized.

NOTICE TO BUYER: This Policy may not cover all medical expenses.
Please see "Benefits" (Article 3) and "Coverage Exclusions" (Article 4) for more information.

PLEASE EXAMINE THIS POLICY CAREFULLY. If, after examination, You are not satisfied with this Policy for any reason, You have the right to return this Policy to Us within 30 days after its delivery date. If You return this Policy within the stipulated 30-day period, the Policy will be considered void as of the original Effective Date and You will receive a refund of premiums paid, less the cost of any benefits provided during the refund period. Please also note that We will be entitled to repayment from You for the cost of any benefits provided to You that exceed the amount paid by You for this Policy.

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POLICY

This Policy describes benefits effective_____, 20__ for the Policyholder,...

This Policy sets forth a program of supplemental medical care benefits for those individuals entitled to and enrolled in both Medicare Part A and Medicare Part B. This Policy provides the evidence and a description of the terms and benefits of coverage.

AllCare agrees to provide benefits for services as described in this Policy, subject to all the terms, conditions, exclusions, and limitations in this Policy, including endorsements affixed hereto. This Policy consists of Your application, this document, and any endorsements, riders, or attached papers, signed by an officer of AllCare. This agreement is in consideration of the premium payments hereinafter stipulated and in further consideration of the application and statements currently on file with Us and signed by You.

This Policy is guaranteed renewable for life, at Your option, by advance payment of premiums when due or within the grace period. We may cancel or refuse to renew this Policy only due to nonpayment of premiums or material misrepresentations made by You that are discovered within two years after the Policy Effective Date.

We reserve the right to change this Policy and/or the associated premiums upon 30 days' prior notice to You, subject to approval by the Oregon Insurance Division. We also reserve the right to automatically increase premiums, upon 30 days' written notice, to coincide with any changes in the applicable Medicare Deductible or copayment/coinsurance amounts, or when Your age places You in a new age category that requires higher premiums.

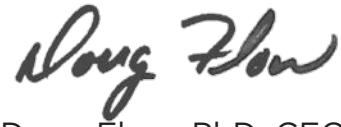
NOTICE OF PRIVACY PRACTICES

AllCare has a Notice of Privacy Practices that is available by calling Member Services or visiting the website listed below.

CONTACT INFORMATION

Member Services: (888) 460-0185

And visit our website at: **AllCareMedigap.com**



Doug Flow, PhD, CEO

AllCare Health Plan, Inc.

Contents

ARTICLE 1. DEFINITIONS

This Policy incorporates by reference all definitions established under Medicare. The definitions that follow are not intended to modify any definitions established under Medicare; and in the event there is any inconsistency between the two, the Medicare definitions shall control.

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

1.2 **"Assignment"** means an agreement between a Physician (or other Provider) and You, whereby You transfer Your right to reimbursements for benefits based on covered services specified on the assigned claim. In return, the Physician (or other Provider) agrees to accept the approved amount determined by Medicare as the full payment for the items or services.

1.3 **"Benefit Period"** is a way of measuring Your use of inpatient services under Medicare Part A. A Benefit Period begins with the first day of a Medicare-covered inpatient Hospital or Skilled-Nursing Facility stay and ends when You have been out of a Hospital or Skilled-Nursing Facility for 60 consecutive days (including the day of discharge). A new Benefit Period starts the next time You enter a Hospital or Skilled-Nursing Facility. There is no limit to the number of Benefit Periods You can have.

1.4 **"Calendar Year"** means the period from January 1 through December 31 of the same year, provided, however, that the first Calendar Year begins on the Policyholder's Effective Date and ends on December 31 of that year.

1.5 **"Deductible"** means the initial amount payable by You as set forth in Section 1813 of Medicare.

1.6 **"Effective Date"** means the first day of coverage for You, following Our receipt and acceptance of Your application.

1.7 **"Guaranteed Issue Rights"** means the right to purchase a Medicare supplement policy without medical underwriting (Pre-Existing Condition waiting periods will not apply) under certain circumstances, typically associated with a loss of other healthcare coverage.

1.8 **"Health Care Expenses"** means expenses associated with the delivery of health care services to a Policyholder.

1.9 **"Hospital"** means a facility approved by Medicare as a hospital that is accredited by The Joint Commission and recognized for payment by Medicare or is approved by Medicare for Medicare hospital benefits. The term does not include any institution, or part thereof, that is other than incidentally a nursing home, convalescent hospital, place of rest for the aged, or facility for substance abuse recovery.

1.10 **"Medically Necessary"** or **"Medical Necessity"** means services or supplies that: (i) are reasonable and necessary for the diagnosis or treatment of Your medical condition; (ii) are used for the diagnosis, direct care, and treatment of Your medical condition; (iii) meet the standards of good medical practice in the local community; and (iv) are not mainly for Your convenience or that of Your doctor. In determining if a service or supply is Medically Necessary, We will follow Center for Medicare and Medicaid Services ("CMS") standards, including without limitation the Medicare National Coverage Decisions ("NCD"s) and applicable local medical review policies ("LMRP"s).

1.11 **"Medicare Eligible Expense"** means healthcare expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

1.12 **"Period of Eligibility"** means the six-month period beginning with the first day of the month in which You first enrolled for benefits under Medicare Part B.

1.13 **"Physician"** means a doctor of medicine ("MD") or osteopathy ("DO"), or other provider recognized as such by Medicare, who is licensed to practice where the care is provided and who is approved by Medicare.

1.14 **"Plan"** means the AllCare MediGap Medicare Supplement Plan G that is described in this document. A Medicare Supplement policy does not include Medicare Advantage plans established under Medicare Part C, Outpatient Prescription Drug plans established under Medicare Part D, or any Health Care Prepayment Plan (HCPP) that provides benefits pursuant to an agreement under Section 1833(a)(1)(A) of the Social Security Act.

1.15 **"Pre-Existing Condition"** means a condition for which medical advice was given or treatment was recommended by or received from a Physician within six months prior to the Policy Effective Date.

1.16 **"Premium Classification"** means the grouping of insureds to which a Policyholder belongs for premium purposes, which is based on attained age and where the Policyholder resides.

1.17 **"Provider"** means any licensed medical professional or supplier, other than a Hospital, Physician, or Skilled-Nursing Facility, who provides services or supplies that are recognized for payment by Medicare.

1.18 **"Policy"** means this document, Your application, and any endorsements, riders, or attached papers that have been signed by an officer of AllCare.

1.19 **"Policyholder"** means an applicant enrolled under this plan whose applicable monthly premium has been received by Us.

1.20 **"Service Area"** means the state of Oregon.

1.21 **"Sickness"** or **"Illness"** means an illness or disease of a Policyholder that manifests itself after the effective date of this Policy and while this Policy is in force. Sickness or Illness does not include sicknesses or diseases for which benefits are provided under any worker's compensation, occupational disease, employer's liability or similar law.

1.22 **"Skilled-Nursing Facility"** means a facility with appropriate staff and equipment to provide skilled-nursing care and/or rehabilitation services and other related health services that is recognized for payment by Medicare. A Skilling-Nursing Facility is also commonly known as or referred to as a convalescent nursing home or extended care facility.

1.23 **"You"** and **"Your"** mean the Policyholder named on the signature sheet of this Policy.

ARTICLE 2. ELIGIBILITY AND ENROLLMENT

2.1 Eligibility.

1. In order to be eligible for coverage under this Policy, You must meet the following requirements.

- **a.** You must be enrolled for benefits under both Parts A and B of Medicare.
- **b.** You must not be covered under any other Medicare supplemental plan.
- **c.** You must reside in Our Service Area six months or more per Calendar Year. We may require You to provide Us with written proof that You meet this residency requirement.

2. If You meet the requirements above and You enroll during Your Period of Eligibility, You cannot be denied enrollment in this Plan regardless of Your age.

3. If You apply for coverage under this Policy six months or more after turning age 65 or enrolling in both Medicare Parts A and B, You must complete an application and health statement and be accepted by Us for coverage under this Policy. The application identifies circumstances under which You do not need to complete a health statement to qualify.

4. Your spouse and other dependents are not eligible for coverage under this Policy but may apply separately, if eligible.

5. Any person covered in error or in violation of any of the terms and conditions of this Policy is not entitled to benefits. We will adjust any premiums paid under such circumstances and have the right to recover from such person the cost of any benefits furnished while covered in error.

6. Fraudulent misstatements made in the Policy application will void the Policy. Any other material misstatement made in the application and discovered within two years of the Effective Date may be used by Us to void this Policy.

2.2 Enrollment.

1. You are entitled to enroll under this Plan without proof of insurability by submitting an application to Us during Your Period of Eligibility. Your qualification for Medicare can be based on Your age or disability. Coverage will be effective on the first day of the month following Our receipt and acceptance of Your application.

2. If You previously had Medicare coverage due to disability, You are entitled to enroll under this Plan without proof of insurability by submitting an application to Us during the six-month period following the first day of the month in which You reach age 65.

3. You may apply for enrollment under this Plan at any time after the expiration of Your Period of Eligibility by submitting an application and health statement form to Us. We have the right to accept or reject Your application. If accepted, coverage will become effective on the first day of the month following Our acceptance of the application.

4. If You lose coverage under another plan that coordinated benefits with Medicare, under circumstances specified by federal and Oregon law, You are entitled to enroll under this Plan without proof of insurability by submitting to Us an application and evidence of the date of termination no later than 63 days after the date Your other coverage was terminated.

ARTICLE 3. BENEFITS

3.1 Benefits Determination.

1. This Policy supplements benefits provided under Medicare. Unless benefits are payable under Medicare or otherwise specifically covered under this Policy, no benefits will be provided under this Policy.

2. Benefits paid by Us for covered services and supplies under this Policy are subject to review for Medical Necessity in accordance with Medicare rules and regulations.

3. Benefits in this Policy that cover cost-sharing amounts under Medicare will be automatically changed to coincide with any changes in the applicable Medicare Deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

3.2 Benefits.

Subject to certain exclusions (see **Article 4**) and the other terms and conditions of this Policy, We will provide the following benefits for as long as such services are covered by Medicare and while You continue to be covered under this Policy.

1. *Basic "Core" Benefits.*

a. Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Benefit Period.

b. Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.

c. Upon exhaustion of the Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Eligible Expenses for hospitalization paid at the prospective payment system ("PPS") rate or other appropriate Medicare standard of payment subject to a lifetime maximum benefit of an additional 365 days. The Provider is required to accept Our payment as payment in full and may not bill You for any balance.

d. Coverage under Medicare Parts A and B for the reasonable costs of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

e. Coverage for the coinsurance amount or, in the case of Hospital outpatient department services paid under a PPS, the copayment amount of Medicare Eligible Expenses under Part B regardless of Hospital confinement, subject to the Medicare Part B Deductible.

f. Coverage of cost sharing for all Medicare Part A eligible hospice care and respite care expenses.

2. *Medicare Part A Deductible*. Coverage for all the Medicare Part A inpatient Hospital Deductible amounts for each Benefit Period.

3. *Skilled-Nursing Facility Care*. Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Benefit Period for post-Hospital

Skilled-Nursing Facility care eligible under Medicare Part A.

4. *Medically Necessary Emergency Care in a Foreign Country*. For services not covered by Medicare, this Plan pays 80 percent of billed charges, not to exceed the amounts allowed by Medicare for the same services incurred in the United States for Medically Necessary emergency Hospital, Physician, and medical care received in a foreign country, when the care would have been covered by Medicare if provided in the United States and when the care began during the first 60 consecutive days of each trip outside the United States. Benefits are subject to a Calendar Year Deductible of $250 and a lifetime maximum benefit of $50,000. For purposes of this benefit, "emergency care" means care needed immediately because of an injury or illness of sudden and unexpected onset.
5. *One Hundred Percent of Medicare Part B Excess Charges*. Coverage for the difference between the Medicare Part B charges as billed, not to exceed any limits established by the Medicare program or state law, and the Medicare-approved Part B charge.

3.3 Pre-existing Condition Limitations.

1. Except as provided in Paragraphs 2 and 3 below, this Policy will not pay for any expenses incurred for care or treatment of a Pre-Existing Condition for the first six months from the Effective Date of coverage.
2. Creditable coverage may reduce or eliminate the 6-month waiting period. Upon purchase of this policy if at such time You have continuously maintained a qualifying insurance policy, or if this Policy replaces another Medicare supplement policy or certificate, We shall waive any time periods applicable to Pre-Existing Conditions, waiting periods, elimination periods, and probationary periods in this Plan to the extent such time was spent under the qualifying policy then in existence, or that is being replaced in the case of another Medicare supplement policy or certificate (for example, if You were covered under a qualifying policy without a break in coverage for 4 months, the waiting period described in Paragraph 1 above would be 2 months instead of 6, and if the qualifying policy was in effect for at least 6 months without a break in coverage, there would be no waiting period).
3. You purchase this Policy when You have Guaranteed Issue Rights, or in any other circumstance where Pre-Existing Condition waiting periods are prohibited by law.

ARTICLE 4. COVERAGE EXCLUSIONS

This Policy is subject to certain exclusions from coverage. However, no limitations or exclusions on coverage under this Policy will be more restrictive than those of Medicare.

4.1 Exclusions from Coverage.

We will not provide benefits for any of the following.

1. Services and/or supplies that would duplicate Medicare's payment.
2. Services or supplies excluded by Medicare, unless otherwise specifically covered under this Policy.
3. Prescription medications.

4. Vision aids (except when required following Medicare covered cataract surgery, after which a Policyholder's vision is greatly changed and therefore, as a result and extension of the covered surgical benefit, individuals require new vision hardware (aids). Payment for this benefit applies as between Medicare, MediGap, and the Policyholder as follows: Policyholder pays the Part B deductible, Medicare generally pays 80% of the balance, MediGap pays the remaining 20% co-insurance, and the Policyholder has no further financial responsibility.)

5. Any services or supplies provided by a Physician, Hospital, Skilled-Nursing Facility, or any other Provider that is not recognized as payable under Medicare, except as otherwise specifically covered under this Policy. This includes services provided by a provider who has opted out of Medicare and who must by federal law enter into an agreement with You regarding Your liability for the care that provider gives You.

6. Services or supplies furnished, paid for, or made available by any state or federal agency or under any law for which You are not required to pay, including but not limited to Title XVIII of the Social Security Act of 1965, as amended – Medicare (except State of Oregon owned or operated hospitals and state-approved community mental health programs).

7. Services or supplies furnished, paid for, or made available under any state or federal workers' compensation, employer liability, or occupational disease law or any motor vehicle no-fault law.

8. Services and supplies for treatment of illness or injury for which a third party is or may be responsible.

9. Care that is of a "custodial" nature. Care is considered custodial when it is primarily for the purpose of meeting personal needs and could be provided by persons without professional skills or training. Much of the care provided in nursing homes or by home health agencies to persons with chronic, long-term illnesses or disabilities falls into this category. Medicare does not cover care if is mainly of a custodial nature.

10. Conditions caused by or arising out of war or acts of war, whether declared or undeclared.

11. We may choose to deny payment of benefits for otherwise covered services when You have received a recovery from another source relating to an illness or injury for which We have previously paid benefits. In such event, We will deny payment of benefits only until the total amount excluded under this provision equals the third-party recovery. The amount of any exclusion under this provision, however, will not exceed the amount of benefits previously paid in connection with the illness or injury for which the recovery has been made.

ARTICLE 5. PREMIUMS AND PAYMENT

1. Premiums are due and payable in advance. You must pay Your monthly premiums on or before the first day of each month. Services You receive after the end of the last month for which You have paid premiums will not be covered by Us.

2. If Your monthly premium payment is late but is received by Us within 30 calendar days after the due date (the "Grace Period"), Your coverage will resume as if the premium was not late. If Your monthly premium is not received by Us before expiration of the

Grace Period, this Policy will automatically terminate. We are not obligated to provide You with notice of such termination. If Your monthly premium has not been paid within the Grace Period and We or an authorized agent accepts a subsequent premium, the Policy may be reinstated, except when an application for reinstatement is required to be submitted by You and accepted by Us.

3. Your monthly premium will automatically increase on the anniversary date of this policy when You reach an age in a higher-premium bracket, even if a lower premium has been prepaid beyond that date.

4. Benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare Deductible amount and copayment percentage factors. Upon prior approval from the Oregon Insurance Division, premiums may be modified to correspond with such changes.

5. We reserve the right to change the applicable premiums upon 30 days' advance notice. Your payment of **new premium rates** shall be conclusive proof of Your agreement to such changes. Premium rates may only be increased once in a 12-month period however.

6. If You qualify for Medicare due to disability and You obtain this Plan during Your Period of Eligibility, Your premium classification will be based on Your age and will not be increased due to Your disability.

ARTICLE 6. PLAN ADMINISTRATION

6.1 Claims Administration.

1. *Claim Forms*. Written notice of any loss resulting in a claim being filed under this Policy must be provided to Us within 20 days after the loss occurs, or as soon as reasonably possible. When We receive the notice of loss, We will send You forms necessary for filing proof of the loss. If We do not furnish the forms within 15 days after receiving Your notice of a claim, You will be deemed to have complied with this requirement.

2. A Provider of services is required by Medicare to submit claims for covered services directly to Medicare on Your behalf. Many Providers will also submit claims for balances not covered by Medicare directly to Us on Your behalf. In the event a Provider of services bills You directly for the balance not covered by Medicare, You are responsible for submitting the "Explanation of Benefits" ("EOB") and an itemized statement to Us.

3. *Proof of Loss*. You must provide Us with written proof of loss within 90 days after the date of the loss for which a claim is made. We will not deny or reduce any claim if it was not reasonably possible for You to give Us proof in the time required. In any event, You must give Us proof within one year after it is due, unless You are incapable of doing so.

4. We will pay benefits for any loss covered under this Policy immediately upon receipt of proof of loss that contains all necessary information. Losses for which this Policy provides periodic payment will be paid on a monthly basis. Benefits payable under this Policy will be paid to You (except as provided in **Paragraph 5** below). Indemnity for loss of life will be payable according to the beneficiary designation in effect at the time of payment. If there is no such designation, payment due at the time of Your

death will be paid to Your estate. If any payment under this Policy is payable to Your estate, or to a beneficiary who is a minor or otherwise incompetent to provide a valid release, We may pay such payment, up to a maximum of $1,000, to:

a. any relative by blood or by marriage to the Policyholder; or

b. a beneficiary deemed by Us to be equitably entitled.

Any payment made by Us in good faith pursuant to this provision fully discharges Us to the extent of such payment.

5. Where a Physician or Provider has accepted Assignment, We will make payments directly to the Physician or Provider. Payment will not exceed Medicare Eligible Expenses for Physicians or Providers accepting Assignment. If the Physician or Provider does not accept Assignment, benefit payments will be made directly to You. Payment will not exceed Medicare Eligible Expenses for Physicians or Providers not accepting Assignment.

6. If We pay a benefit to which You were not entitled under this Policy, or if We pay benefits on behalf of a person who is not eligible for benefits at all, We have the right to recover the payment from the person We paid or from anyone else who benefited from it, including a Provider of services. Our right to recovery includes the right to deduct the mistakenly paid amount from future benefits We would otherwise pay to You. We regularly work to identify and recover claims payments that should not have been made (for example, claims that are the responsibility of another, duplicates, errors, and fraudulent claims). We will credit all amounts that We recover, less Our reasonable expenses for obtaining the recoveries, to the experience of the pool under which You are rated. Crediting reduces claims expense and helps reduce future premium rate increases. This claims recovery provision in no way reduces Our right to reimbursement or subrogation (see Section 6.2 below for additional information).

7. We will not provide coverage under this Policy for any medical expenses You incur for treatment of an injury or illness if the costs associated with the injury or illness may be recoverable from any of the following:

a. a third party;

b. workers' compensation; or

c. any other source, including automobile medical, personal injury protection ("PIP"), automobile no-fault, homeowner's coverage, commercial premises medical coverage or similar contract or insurance, when the contract or insurance is either issued to or makes benefits available to You, whether or not You make a claim under such coverage.

However, We may choose, at Our sole discretion, to advance benefits for covered services if You otherwise satisfy the requirements described in **Paragraphs 1–7** of **Section 6.2** below.

8. In the event You sustain an injury or illness that is potentially covered by workers' compensation insurance, You must notify Us in writing within five business days of the occurrence of any of the following:

a. filing a workers' compensation claim;

b. acceptance or rejection of the claim;

c. appealing any decision on the claim;

d. settling or otherwise resolving the claim; or

e. any other change in status of Your claim.

If the workers' compensation carrier denies Your claim and You have filed an appeal, We may choose, at Our sole discretion, to advance benefits for covered services if You otherwise satisfy the requirements described in **Paragraphs 1–7** of **Section 6.2** below.

9. We have the right to require You to be examined, at Our expense, when and as often as reasonably required to make determinations regarding Your pending claims. We also have the right to request, at Our expense, an autopsy in the event of Your death, unless it is otherwise forbidden by law.

6.2 Third-Party Responsibility; Our Subrogation Rights.

Situations may arise in which Your medical expenses are the responsibility of a source other than Us. If You have a potential right of recovery for an illness or injury caused by a third party who may have legal responsibility for Your medical expenses, or from any other source (such as the third-party's insurer), We may choose to advance benefits to You, pending the resolution of a claim to the right of recovery. In order for Us to consider advancing benefits to You under these circumstances, the conditions described in **Paragraphs 1–7** below must be satisfied. In the event We do advance benefits to You, We do not waive our right to reimbursement or subrogation.

1. By accepting or claiming benefits, You agree that We are entitled to reimbursement of the full amount of benefits that We have paid, out of any settlement or recovery You receive from any source. This includes but is not limited to any judgment, arbitration award, settlement, uninsured motorist payment, or any other recovery related to the injury or illness for which We have provided benefits.

2. We may choose instead to exercise Our rights through subrogation. In such event, We are authorized, but not obligated, to recover any benefits We have paid directly from any party liable to You. If We exercise our subrogation rights, We will mail a written notice to the potential payer, to You, or to Your representative.

3. Our right of reimbursement or subrogation applies without regard to the source of payment for medical expenses, whether from the proceeds of any settlement, arbitration award or judgment, or other characterization of the recovery by You and/or any third party or the recovery source. This applies regardless of whether:

a. the third party or third party's insurer admits liability;

b. the medical expenses are itemized or expressly excluded in the recovery; or

c. the recovery includes any amount (in whole or in part) for services, supplies, or accommodations covered under this Policy.

4. Unless Oregon law requires otherwise, We will not reduce Our reimbursement or subrogation due to Your not being made whole. Our right to reimbursement or subrogation, however, will not exceed the amount of recovery.

5. We may require You to sign and deliver to Us certain legal documents and to take any other actions We request to secure Our rights, including specifically, but not limited to, an assignment of the right to pursue Your claim if You fail to do so, and/or a trust

agreement or other document that obligates You to reimburse Us from the proceeds of any recovery.

6. You must agree that nothing will be done to prejudice Our rights and that You will cooperate fully with Us, including signing any documents within the required time and providing prompt notice of any settlement or other recovery. You must notify Us of any facts or circumstances that may impact Our right to reimbursement or subrogation, including but not limited to:
   a. filing a lawsuit or other claim against a third party;
   b. scheduling settlement negotiations (We require at least 15 days' advance written notice of the date, time, location, and participants to be involved in any settlement conferences or mediations); or
   c. notification that a third party intends to make, or has made, payment of any kind for Your benefit or on Your behalf and that in any manner relates to the injury or illness that gives rise to Our right of reimbursement or subrogation.
7. You and/or Your agent or attorney must agree to keep segregated in a trust account any recovery or payment of any kind for Your benefit or on Your behalf that in any manner relates to the injury or illness giving rise to Our right of reimbursement or subrogation, until Our right is satisfied or released.
8. In the event You fail to comply with any of the requirements described in **Paragraphs 1–7** above and Our right of reimbursement or subrogation is jeopardized, We may recover any such benefits advanced for any illness or injury through legal action.
9. We are not liable for any expenses or fees incurred by You in connection with obtaining a recovery (for example, attorneys' fees or court costs). However, You may request that We pay a proportional share of attorneys' fees and costs at the time of any settlement or recovery to otherwise reduce the required reimbursement amount to less than the full amount of benefits paid by Us. Whether we pay such proportional share of attorneys' fees and costs is at our discretion, however.

6.3 Duplication of Benefits.

For coordination of coverage purposes, We will not pay benefits for covered services to the extent that You have any other coverage for those services, without regard to any other coverage's coordination of benefits provision. This other coverage may be in the form of group or individual heath coverage (whether insured or self-insured) or a Hospital or medical benefit or service plan. However, if We deny or reduce payment on a claim for benefits because of duplicate coverage, the resulting benefit savings will be used to pay up to 100 percent of covered expenses incurred during the Calendar Year (so long as this Policy remains in effect).

6.4 Medical Records.

1. You have the right to request, inspect, and amend any records that We have that contain Your personal health information. Please contact Our Member Services Department to make this request.
2. Your personal health information may be requested or disclosed by Us. This information will be used for the purpose of facilitating healthcare treatment, payment of claims, and/

or business operations necessary to administer healthcare benefits, or as required by law. We are required by law to protect Your personal health information, and we must obtain prior written authorization from You to release information not related to routine health insurance operations.

3. We may not request from You or any other source information regarding HIV/AIDS, psychotherapy notes, alcohol/drug services, or genetic testing without first obtaining from You a specific authorization to allow Us to do so.

4. A Notice of Privacy Practices is available by calling Our Member Services Department or visiting Our website: **AllCareMedigap.com**.

ARTICLE 7. GRIEVANCES AND APPEALS

We encourage You to promptly contact our Member Services Department if You have a question about or a complaint that arises out of this Policy. If Your question or complaint is not resolved to Your satisfaction by Our Member Services Department, You may exercise Your grievance and appeal rights described below. We will assist You in filing a grievance when You have a complaint and ask for help to put it into writing.

If You have any questions about the appeal process, You may contact Our Member Services department at (888) 460-0185, or You can write to Our Member Services Department at the following address: 1701 NE 7th St, Grants Pass, OR 97526.

Appeals can be initiated through either a written or a verbal request but must be followed up in writing. Written requests can be submitted to Us at: Appeals Coordinator, AllCare MediGap, 1701 NE 7th St, Grants Pass, OR 97526. Verbal requests can be made by calling Us at (888) 460-0185.

Where Medicare is the primary payor for covered services, appeals should first be directed to Medicare's appeal process.

1. *Initial Appeal*. If You are dissatisfied with a denial of a claim or any other act by Us, You may file a request for appeal within 60 days of the date You receive Our denial letter. Your request should be filed with Our Appeals Coordinator and should include information in support of Your appeal. We will acknowledge receipt of Your request for appeal within 7 days and report Our decision to You within 30 days ("Initial Decision"). However, We have the right to extend the 30-day time period by an additional 15 days if We do so within the first 30 days and provide to You the particular reason(s) for Our delay. When We report Our Initial Decision to You, We will also provide You with additional information concerning Your further appeal rights.

2. *Secondary Appeal*. If You are dissatisfied with Our Initial Decision, You may seek a secondary appeal by requesting such appeal within 60 days of the date You receive Our Initial Decision. Your request for a secondary appeal should be made to Our Appeals Coordinator. Your secondary appeal will be considered by an "appeals committee" composed of persons who were not involved in the Initial Decision. We will acknowledge receipt of Your request for appeal within 7 days and report Our decision to You within 30 days ("Final Decision"). When we report Our Final Decision to You, We will also provide You with additional information concerning Your arbitration rights.

3. You have the right at any time to file a complaint with, or seek further assistance from,

the Division of Financial Regulation. Assistance is available by calling (503) 947-7984; by writing to: Division of Financial Regulation, Consumer Protection Unit, 350 Winter Street NE, Salem, OR 97301; or through the Internet at **http://dfr.oregon.gov**.

4. No legal action may be brought to recover on this Policy until 60 days after proof of loss has been furnished to Us (see **Section 6.1** for further information concerning proof of loss). No legal action may be initiated against Us after three years from the time written proof of loss is required to be furnished.

ARTICLE 8. POLICY TERM AND TERMINATION

8.1 Policy Term.

This Policy becomes effective at 12:01 a.m. on the Effective Date. This Policy will remain in effect for as long as Your premiums are paid to Us and You remain eligible for coverage (see **Section 2.1**).

8.2 Policy Termination.

1. We have the right to cancel or not renew this Policy under the following circumstances.

- **a.** You fail to make premium payments within the time required by this Policy (see **Paragraph 5** below regarding Grace Periods for premium payment).
- **b.** You make a material misrepresentation in connection with coverage that We discover within two years after the Policy Effective Date.

We have issued this Policy in reliance upon all information furnished to Us by You or on behalf of You, and We will take any action allowed by law or contract, including denial of benefits, termination of coverage, and/or pursuit of criminal charges and penalties.

2. You have the right to terminate this Policy by giving notice to Us within 30 days. Coverage will end on the last day of the calendar month following the date We receive such notice so long as the premium has been received for the calendar month.

3. If You die, coverage ends on the last day of the calendar month in which Your death occurs so long as the premium has been received for the calendar month.

4. If this Policy is terminated or not renewed by You or Us, coverage ends for You on the last day of the calendar month in which this Policy is terminated or not renewed so long as the premium has been received by Us for the calendar month.

5. If You fail to make premium payments within the time required, Your coverage will end. A Grace Period of 30 days will be granted for the payment of premiums. During this Grace Period, this Policy shall not be terminated. However, if the premium has not been received during the Grace Period, this Policy shall be terminated at the end of the month for which the last premium payment was paid to Us, not at the end of the Grace Period.

6. Termination of Your coverage under this Policy for any reason will completely end all of Our obligations to provide You benefits received after the date of termination, except as otherwise provided in **Paragraph 7** below. This applies whether or not You are then receiving treatment or are in need of treatment for any illness or injury incurred or treated before or while this Policy was in effect.

7. Termination of this Policy shall be without prejudice to any continuous loss which commenced while the Policy was in force, but Our extension of benefits beyond the period during which the Policy was in force may be conditioned upon Your continuous total disability, limited to duration of the Policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

8. Time Limit on Certain Defenses. After two years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by You in the application for coverage under this Policy shall be used to void this Policy or to deny a claim for loss incurred or disability, as defined in this Policy, commencing after the expiration of that period.

9. No right of conversion is allowed upon termination of this Policy.

8.3 Guaranteed Renewability.

This Policy is guaranteed renewable, at the option of the Policyholder, upon payment of the premium when due or within the Grace Period. We may refuse to renew this Policy only for nonpayment of premium or a material misrepresentation by You that is discovered within two years after the effective date of this Policy. We cannot refuse to renew this Policy because of Your health status.

8.4 Birthday Selection Rule.

Beginning on Your birthday, and for 30 days after, You may cancel this Policy and purchase another Medicare supplement policy with the same or lesser benefits to replace this Policy. We will not deny or condition the issuance or effectiveness, nor discriminate in the pricing of the replacement policy or certificate on the basis of health status, claims experience, receipt of health care or medical condition.

8.5 Policy Suspension During Disability and Coverage Under a Group Health Plan.

1. The coverage under this Policy shall be suspended at Your request, for any period of time provided by federal regulation, in which You are entitled to benefits under Section 226(b) of the Social Security Act and while You have coverage under a group health plan.

2. If such suspension occurs and You lose coverage under the group health plan, coverage under this Policy shall automatically be reinstated effective as of the date of such loss of coverage if You provide notice to Us within 90 days of the date You lose coverage under the group health plan and You pay the required premiums attributable to the period of suspension. You will be entitled to retain Your original Premium Classification, and coverage will be substantially equivalent to coverage in effect before the date of such suspension. Your Premium Classification shall be no less favorable to You than if Your coverage had not been suspended.

8.6 Policy Suspension During Medicaid Eligibility.

1. Benefits and premiums under this Policy shall be suspended at Your request for the period, not to exceed 24 months, in which You have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act but only

if You notify Us in writing within 90 days after the date You become entitled to such assistance. Upon receipt of timely written notice, We shall return to You the portion of the premiums attributable to the period of Medicaid eligibility, subject to adjustment for paid claims.

2. If such suspension occurs and if You lose entitlement to medical assistance, and coverage under Medicare Parts A and B is still in effect, this Policy shall automatically be reinstated effective as of the date of such loss of entitlement if You provide notice to Us within 90 days of the date You lose Medicaid entitlement and You pay the required premiums attributable to the period of suspension. You will be entitled to retain Your original Premium Classification, and coverage will be substantially equivalent to coverage in effect before the date of such suspension. Your Premium Classification shall be no less favorable to You than if Your coverage had not been suspended.

ARTICLE 9. GENERAL POLICY PROVISIONS

1. This Policy, including the Policyholder's application, endorsements, and any other attachments, constitutes the entire contract of insurance. No change in this Policy is valid until approved by one of Our executive officers, which approval shall be in writing and become an endorsement or attachment to this Policy. No other agent or employee is authorized to change this Policy or waive any of its provisions.

2. We have the right to modify or amend this Policy, including the premium amounts due hereunder, from time to time. However, no benefit modifications or premium adjustments shall become effective until 30 days after written notice is provided to You describing the change(s). No change will be made by Us in this Policy unless the same change is made in all policies of the same form and class. Payment of new premium rates by You after receiving notice of premium changes constitutes Your acceptance of the premium rate change. Changes to this Policy by Us can be made only through a modified Policy, amendment, endorsement, or rider authorized and signed by one of Our executive officers. No other agent or employee is authorized to change this Policy.

3. This Policy is issued and delivered in the state of Oregon and will be governed by and construed in accordance with Oregon law without regard to its conflict-of-law rules, except where federal Medicare guidelines supersede state law. Any legal action arising out of this Policy must be filed in a court in the state of Oregon.

4. In case of any dispute under this Policy that becomes the subject of any arbitration or legal proceeding, You, on behalf of Yourself and Your heirs and representatives, expressly waive the privileges and benefits of any and all laws and rules that are now in force or are later enacted or promulgated with regard to disqualifying from testifying any doctor, nurse, Hospital official or employee, or any other person or organization providing medical services, supplies, or accommodations. This concerns any information obtained by such person or organization in a professional capacity or other capacity that makes such information or knowledge privileged. You, on behalf of Yourself and Your heirs and representatives, expressly authorize and request such doctor, nurse,

Hospital official or employee, or other person or organization to make full disclosure in the arbitration or legal proceeding concerning Our liability for such benefits.

5. Nothing contained in this Policy is designed to restrict You in selecting the Provider of Your choice for care or treatment of an illness or injury.

6. In all cases, You have the exclusive right to choose a healthcare Provider. This Policy contemplates payment for, and not the procuring or providing of, medical, surgical, Hospital, or other medical services You may require. As a result, We are not responsible for the quality of healthcare You receive. Because We do not provide any healthcare services, We cannot be held liable for any claim or damages connected with injuries You suffer while receiving health services or supplies provided by professionals who are neither Our employees nor Our agents. In addition, We will not be liable to any person or entity for the inability or failure to procure or provide the benefits of this Policy by reason of epidemic, disaster, or other cause or condition beyond Our control.

7. No benefit, right, or interest under this Policy may be assigned or transferred. Any attempted assignment or transfer will be invalid and void. We may, however, choose to make payments directly to a Provider of services.

8. The failure or refusal of either party to demand strict performance of this Policy or to enforce any provision will not act as or be construed as a waiver of that party's right to later demand its performance or to enforce that provision. No provision of this Policy will be considered waived by Us unless such waiver is reduced to writing and signed by one of Our authorized executive officers.

9. Any notice to You that is required or otherwise provided for in this Policy will be considered to be properly given if written notice is deposited in the US mail or with a private carrier. Notices We send to You will be addressed to Your last known address appearing in Our records. If We receive a US Postal Service change of address form for You, We will update Our records accordingly. Any notice to Us required in this Policy may be given by mail addressed to: **AllCare MediGap, 1701 NE 7th St, Grants Pass, OR 97526**; provided, however, that any notice to Us will not be considered to have been given to and received by Us until physically received by Us.

10. In order for health expenses to be covered under this Policy, they must be incurred while coverage is in effect. Coverage is in effect when all of the following conditions are met.

- **a.** The person is eligible to be covered according to the eligibility provisions of this Policy (see **Section 2.1** hereof).
- **b.** The person has applied and been accepted for coverage by Us.
- **c.** Premiums have been paid on a timely basis.

The expense of a service is incurred on the day the service is provided to You, and the expense of a supply is incurred on the day the supply is delivered to You.

11. By electing coverage or accepting benefits under this Policy, You agree to all terms, conditions, and provisions set forth in this Policy. We may adopt reasonable policies, procedures, rules. and regulations, including interpretations of any of the foregoing, not inconsistent with this Policy and the Plan, in order to promote orderly and efficient Policy and Plan administration.

Grants Pass 1701 NE 7th Street, Grants Pass, OR 97526 Tel (541) 471-4106
Medford 3629 Aviation Way, Medford, OR 97504 Tel (541) 734-5520

Toll free (888) 460-0185 **TTY** (800) 735-2900 **Fax** (541) 471-3784 **AllCareMediGap.com**