2025

Moda Health Medicare Supplement Plan

Plan High-deductible G

NOTICE TO BUYER: This Policy may not cover all of your medical expenses

POLICY RENEWAL:
This is a guaranteed renewable plan. The required premium for the plan is subject to change. Additional information about these disclosures is in Section 1 of this policy.

IMPORTANT:
If for any reason a subscriber decides not to purchase this policy, they may return it to Moda Health within 30 days of delivery and have the premium paid refunded. Upon receipt, this policy will be deemed void from its effective date.

Scott Loftin
Senior Vice President

Health plans provided by Moda Health Plan, Inc.

ModaTXMedSupHDGbk 1-1-2025

Handbooks and other services are available at www.modahealth.com.

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SECTION 1 DISCLOSURES

1.1 30-DAY RIGHT TO EXAMINE THE POLICY

If for any reason a subscriber decides not to purchase this policy, they may return it to Moda Health within 30 days of delivery and have the premium paid refunded. Upon receipt, this policy will be deemed void from its effective date and Moda Health will hold the position as if no policy had been issued. This policy, with a written request for withdrawal, must be sent to:

Moda Health
Medicare Membership Accounting
601 S.W. Second Ave.
Portland, OR 97204

1.2 NOTICE TO BUYER

The Plan may not cover all medical expenses.

1.3 ADDITIONAL DISCLOSURES

The Plan is provided by Moda Health Plan, Inc.

The Plan is guaranteed renewable, which means Moda Health cannot refuse to renew the policy unless the subscriber does not pay the premiums on time, or if within 2 years of the date of application, it is discovered that the subscriber made material misrepresentations on the application.

If this Policy has terminated because the premiums were not paid, Moda Health may choose to accept late premium at a later date and reinstate the policy as a one-time exception. The request for a one-time exception must be made within 60 days of the termination date. The reinstatement will be effective back to the date coverage terminated, provided the full premium for that full period is paid within the specified timeframe.

The reinstated policy only covers claims resulting from an accidental injury sustained after the date of reinstatement and loss due to sickness that begins more than 10 days after the date of reinstatement. In all other respects you have the same rights under the reinstated policy as you had under the policy immediately before the due date of the missed premium, as long as you pay the full amount of missed premium (limited to 60 days before the reinstatement date) within the specified timeframe.

The required premium for the Plan is subject to change. Any change in premium will occur once in a 12-month period after approval by the Texas Department of Insurance, and will apply to all subscribers insured under the Plan who reside in the state of Texas. When the subscriber moves into the next age bracket of the rate table, premiums will change on the renewal date.

This policy is renewed each time a subscriber makes a timely premium payment.

Medicare may, from time to time, change its deductible, coinsurance, and copayment amounts. When this happens, the Plan will automatically cover the changed amounts that are eligible for benefits.

At least 30 days prior to the annual renewal date, Moda Health will provide subscribers a written notice of any change in benefits.

1.4 MEMBER RESOURCES

Moda's Website (log in to the Member Dashboard)
www.modahealth.com

Medical Customer Service Department
Toll-free 844-235-8012;
En Español 844-235-8012

Telecommunications Relay Service for the hearing impaired
711

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

SECTION 2 DEFINITIONS

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

Approved Amount means the amount Medicare determines to be reasonable for a service that is covered under Medicare Part B. It may be less than the actual charge. For many services, including physician services, the approved amount is taken from a fee schedule that assigns a dollar value to all Medicare-covered services that are paid under that fee schedule.

Assignment means an arrangement in which a physician or medical supplier agrees to accept the Medicare-approved amount as full payment for services and supplies covered under Part B. Medicare usually pays 80% of the approved amount directly to the physician or supplier after the subscriber meets the annual Part B deductible. The subscriber pays the other 20%.

Benefit Period is a way of measuring a subscriber's use of hospital and skilled nursing facility services covered by Medicare. A benefit period begins the day the subscriber is hospitalized. It ends after the subscriber has been out of the hospital or other facility that primarily provides skilled nursing or rehabilitation services (or, if in the latter type of facility, has not received skilled care there) for 60 days in a row. If the subscriber is hospitalized after 60 days, a new benefit period begins, most Medicare Part A benefits are renewed, and the subscriber must pay a new inpatient hospital deductible. There is no limit to the number of benefit periods a subscriber can have.

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

Health care expenses means expenses associated with the delivery of health care to the subscriber.

Hospital means a Medicare approved institution that provides care for which Medicare pays hospital benefits.

Injury means physical damage to the body inflicted by a foreign object, force, temperature or corrosive chemical that is the direct result of an accident, independent of illness or any other cause.

Lifetime Reserve Days are a lifetime reserve of 60 days for Medicare Part A inpatient hospital care. These days must be used whenever more than 90 days of inpatient hospital care are needed in a benefit period.

Limiting Charge is the maximum amount a physician may charge a Medicare beneficiary for a covered physician service if the physician does not accept assignment of Medicare claims. The limit is 15% above the fee schedule amount for non-participating physicians. Limiting charge information appears on the Medicare Summary Notice (MSN).

Medicaid is a program established under Title XIX of The Social Security Disability Act to help some people with limited income and resources regarding their medical costs.

Medicare is Parts A and B of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Medicare Eligible Expenses are expenses of the kind covered by Medicare to the extent recognized as reasonable and medically necessary by Medicare.

Medicare Part A Inpatient Hospital Deductible is the amount normally due from a subscriber upon first admission to a hospital in each benefit period, before benefits are available under Part A of Medicare.

Medicare Part B Deductible is the amount a subscriber must pay each calendar year before Part B of Medicare pays benefits for Medicare Part B expenses.

Medicare Part B Excess Charge is the amount for a service or supply that exceeds the Medicare approved amount. Physicians who do not accept assignment of a Medicare claim can charge a subscriber up to 15% more than the Medicare-approved amount. The Medicare approved amount is also called the limiting charge.

Medicare Summary Notice (MSN) is a form Medicare sends to a beneficiary every three months showing all services and supplies billed to Medicare during the 3-month period, what Medicare paid, and what the beneficiary may owe the provider.

Moda Health refers to Moda Health Plan, Inc.

Newly Eligible means an individual who became eligible for Medicare due to age, disability or end-stage renal disease on or after January 1, 2021.

Physician means a licensed practitioner of the healing arts acting within the scope of their license.

Plan means the Medicare supplement plan coverage provided under this policy.

Policy means the contract between the subscriber and Moda Health, which contains all the conditions of the insurance coverage. The policy includes this document, the health statement application with Moda Health and any declaration pages, addendums, endorsements, or amendments. A change in this policy is not valid until the change is approved by an executive

officer of Moda Health and unless the approval is endorsed on or attached to the policy. An agent does not have authority to change this policy or to waive any of its provisions.

Premium means the periodic payment required from the subscriber in order for the subscriber to have coverage under the Plan.

Sickness means illness or disease of the subscriber that manifests itself after the effective date of insurance and while the insurance is in force.

Skilled Nursing Facility is a facility that provides skilled nursing care and is approved for payment by Medicare.

Subscriber means the person in whose name the policy is issued following acceptance by Moda Health of that person's health statement application.

SECTION 3 SUMMARY OF BENEFITS

This section lists the benefits under the Plan.

Plan High-deductible G

The Plan pays benefits after the subscriber has met a calendar year deductible of $2,870. The deductible is satisfied when the subscriber has accumulated $2,870 in expenses that would ordinarily be paid by the Plan. This includes the Medicare deductible for Part A and the subscriber's payment of the Part B deductible. It does not include the Plan's separate foreign travel emergency deductible.

3.1 CORE BENEFITS

All Medicare supplement plans cover Core Benefits. Core Benefits are:

a. The Part A hospital coinsurance amount for days 61 through 90 of hospitalization in each Medicare benefit period.

b. The Part A hospital coinsurance amount for each of Medicare's 60 non-renewable lifetime hospital inpatient reserve days.

c. 100% of the Medicare Part A eligible hospital expenses after all Medicare hospital benefits are exhausted. Coverage is limited to a maximum of 365 days of additional inpatient hospital care during the subscriber's lifetime. This benefit is paid at the rate Medicare pays hospitalization under the applicable prospective payment system (PPS) or another appropriate Medicare standard of payment.

d. The first 3 pints of blood or equivalent quantities of packed red blood cells under both Part A and Part B per calendar year, unless replaced in accordance with federal regulations, and the coinsurance amount (20%) for additional pints of blood under Part B after the Part B deductible is met.

e. The coinsurance or copayment amount of Medicare eligible expenses under Part B after the Medicare Part B deductible is met.

f. The Part A eligible hospice care and respite care coinsurance amount.

3.2 ADDITIONAL BENEFITS

Plan High-deductible G includes these additional benefits:

a. The Medicare Part A inpatient hospital deductible.

b. 100% of Medicare Part B excess charges.

c. The skilled nursing facility care coinsurance amount for days 21 through 100 per benefit period.

d. Medically necessary emergency care in a foreign country at 80% after a $250 calendar year deductible. This benefit is limited to a lifetime maximum of $50,000.

Section 4 has additional details about the benefits under the Plan.

SECTION 4 BENEFIT DESCRIPTION

For covered stays and care, the Plan will pay as shown in Section 3. Section 4 describes the conditions under which benefits are payable for each type of coverage available under the Plan.

Medicare eligible expenses are covered under Parts A and B of Medicare. Part A provides coverage for stays in a hospital or in a skilled nursing facility. Part B covers medical care services and supplies.

Benefits may be paid for any covered charge that is a Medicare eligible expense subject to the same conditions and exclusions that apply under Medicare.

4.1 HOSPITAL CARE

For subscribers confined in a hospital, the benefit amounts as shown in Section 3 for a covered hospital stay will be paid if the following conditions are met:

a. The hospital stay begins on or after the effective date of the policy.
b. The hospital stay is covered under Part A of Medicare during a benefit period.
c. If past day 90 in any one benefit period, the subscriber is utilizing lifetime reserve days; or
d. If all Medicare hospital benefits are exhausted, the Plan will pay all Medicare Part A eligible expenses up to an additional 365 days of inpatient hospital care.

The service provider must accept the Plan's payment as payment in full and may not bill the subscriber for any balance.

4.2 MEDICAL CARE

For medical care eligible for payment under Medicare Part B, the benefits as shown in Section 3 will be paid if the following conditions are met:

a. Medicare Part B has paid a portion of the expenses when required by the Plan.
b. Medical care received as an inpatient occurred during a stay which began on or after the effective date of the policy. Medical care received as an outpatient must be received on or after the effective date of the policy.

4.3 SKILLED NURSING FACILITY STAYS

For skilled nursing facility stays, the Plan will pay the benefit amounts as shown in Section 3 for each covered confinement if the following conditions are met:

a. The skilled nursing facility stay is covered under Part A of Medicare during a benefit period.
b. The skilled nursing facility stay begins within 30 days after an inpatient hospital stay of 3 or more days in a row.
c. If admitted to a skilled nursing facility more than once in a benefit period, the confinement is for the same condition as the first stay in the benefit period.
d. Both the hospital and the skilled nursing facility stay must start while the subscriber is covered under the Plan.

4.4 EMERGENCY MEDICAL CARE IN FOREIGN COUNTRIES

For emergency medical care in foreign countries, the Plan will pay the benefit amounts as shown in Section 3 if the following conditions are met:

a. While on a trip outside the United States, the subscriber needs emergency care. Emergency care means care needed immediately because of an injury or an illness of sudden or unexpected onset.
b. The emergency hospital, physician or medical care received in the foreign country would have been covered by Medicare if provided in the United States.
c. The emergency medical care is not eligible for payment under any Medicare program.
d. The emergency medical care begins during the first 60 days of a trip outside the United States.
e. The emergency medical care lifetime maximum of $50,000 has not been reached.
f. The emergency medical care deductible of $250 per calendar year has been satisfied.
g. The emergency medical care is received on or after the effective date of the policy.

Benefits for emergency medical care in a foreign country are payable only to the subscriber in United States currency in an amount based on the bank transfer exchange rate in effect on the day the claim payment is processed in the United States.

SECTION 5 VALUE-ADDED SERVICES AND DISCOUNTS

With enrollment in this Medicare supplement plan, members are provided with additional value-added services and discounts. Members can learn more about these discounts by visiting the Member Dashboard at www.modahealth.com.

These additional services are a complement to the Medicare supplement plan, but are not insurance. Members may call Customer Service if they have trouble getting services from these vendors. Moda Health will either work with the vendors or make other arrangements to provide the services. These services end when coverage under the Plan ends. Moda Health may also discontinue these services for all policyholders. Before these services are discontinued, notice will be sent 30 days in advance.

5.1 WELLNESS PRODUCTS AND SERVICES

Members have access to the following health and wellness services through ChooseHealthy:

a. Discounts on popular health and fitness brands
b. Savings on services from specialty health practitioners including acupuncture, chiropractic, physical therapy, occupational therapy, therapeutic massage, nutrition services, and podiatry
c. Access to no-cost online health classes

The ChooseHealthy program, provided by ChooseHealthy, Inc., a subsidiary of American Specialty Health Incorporated (ASH), is available at no additional cost to members. The ChooseHealthy program is only available to members who are able to access the program through Member Dashboard at www.modahealth.com.

5.2 TRAVEL ASSISTANCE SERVICES

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

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

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

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

To activate these services, members can call Assist America at 800-872-1414, or reach Assist America by email at medservices@assistamerica.com.

5.3 24-HOUR NURSE ADVICE LINE

Members can use the toll-free 24-hour Nurse Advice Line to speak with a registered nurse. The 24-hour Nurse Advice Line is available at no additional cost to members by calling 800-501-5046.

By calling the Nurse Advisory Line, members can:

a. Access a registered nurse, 24 hours a day, 365 days a year
b. Receive answers and advice about non-critical medical issues

5.4 HEARING SERVICES DISCOUNT

Members have access to discounts for the following hearing aid and hearing aid exam services through TruHearing:

a. Hearing exam plus one year of follow up visits for fitting and adjustments
b. Up to a 60% off retail prices for the latest advances in hearing technology
c. 60-day trial and three-year warranty
d. 80 free batteries per aid for non-rechargeable models

Members can call TruHearing at 855-739-7692 to access these services.

SECTION 6 GENERAL EXCLUSIONS

At-Home Recovery Care
No benefits are available for short term, at-home assistance provided by a home health aide, homemaker, personal care aide, or nurse for activities of daily living. Activities of daily living include but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

Care Provided Without Charge
No benefits are provided for stays, care, or visits for which no charge would be made to the subscriber in the absence of insurance.

Deductibles
No benefits are available for the Medicare Part B deductible.

Duplicate Benefits
In no event will medical payment under the Plan duplicate any amounts payable under Medicare.

Government Hospitals
The Plan will not cover a stay, service, supply, or facility provided by a hospital or other institution owned or operated by a national government or any other government, unless payment of the charge is required by law.

Outpatient Prescription Drugs
No benefits are provided for outpatient prescription drugs, except outpatient drugs covered by Medicare Part A for hospice care.

Preventive Medical Care
Only preventive services covered under Medicare Part B are eligible for benefits.

Services Not Covered by Medicare
No benefits are provided for charges that are not covered expenses under the subscriber's Medicare plan, unless otherwise specifically stated in this handbook.

Workers' Compensation
The Plan will not cover any injury or sickness for which the subscriber is entitled to any benefits under workers' compensation or similar law.

SECTION 7 ELIGIBILITY

7.1 WHO IS ELIGIBLE FOR COVERAGE

Any person who is a Texas resident within the first 6 months of enrolling in Medicare Part B may enroll in any of the supplement plans offered by Moda Health. A subscriber must be enrolled for benefits under Medicare Part A and B to remain eligible under the Plan. Those who have Medicare by reason of disability and would like additional information about the plans available should contact the Senior Health Insurance Benefits Assistance (SHIBA) program at 800-247-4422.

7.2 BENEFITS AFTER COVERAGE STOPS

If the policy is terminated, coverage ends on the date the policy ends. However, if the subscriber is in the hospital on the day the policy ends, the Plan will continue to pay toward covered expenses for that hospitalization until discharged from the hospital or benefits are exhausted, whichever comes first. This is the only situation in which the Plan will pay toward an expense incurred while a person is not covered.

SECTION 8 CLAIMS ADMINISTRATION & PAYMENT

8.1 CLAIM FILING

Electronic claims filing is available. Before the Plan can pay any benefits, the provider of service must file a claim for those expenses with Medicare. Moda Health must receive notification from the Medicare carrier of its payment. If a bill is electronically filed, it will say "This claim has been forwarded to your secondary Medicare payor."

If a subscriber has a claim to submit to Moda Health, it can be mailed, along with the Medicare Summary Notice, to:

Moda Health
PO Box 40384
Portland, OR 97240

A claim must be submitted to Moda Health within 90 days after the date the expense was incurred. If it was not reasonably possible to submit the claim within 90 days, it must be submitted as soon as reasonably possible. In no event, except absence of legal capacity, is a claim valid if submitted later than 15 months from the date the expense was incurred.

Only those charges determined by Medicare to be Medicare eligible expenses will be covered under the Plan.

Notice of Claim and Claim Forms Disclosure
If the provider and Medicare carrier do not file a claim on behalf of the subscriber, a written notice of a claim must be submitted to Moda Health no more than 21 days after the date the expense was incurred, or as soon as reasonably possible. A notice given by or on behalf of the subscriber to Moda Health at 601 SW Second Avenue, Portland, Oregon 97204 or to a Moda Health authorized agent, with information sufficient to identify the subscriber, constitutes notice of claim. After receiving a notice of claim from a subscriber, Moda Health will provide a claims form to the subscriber for filing proof of loss. If the forms are not provided within 16 days after the date of the notice, you can give proof in writing, describe the nature and extent of the expenses incurred, and send the proof.

8.1.1 Out-of-Country Foreign Claims

Out-of-country care is only covered for emergency or urgent care situations. When care is received outside the United States, the subscriber must provide all of the following information to Moda Health:

a. Patient's name, subscriber's name, and group and identification numbers
b. Statement explaining where the subscriber was and why they sought care
c. Copy of the medical record (translated is preferred if available)

d. Itemized bill for each date of service
e. Proof of payment in the form of a credit card/bank statement or cancelled check

8.2 PAYMENT OF CLAIM

Foreign travel emergency care benefits will be payable directly to the subscriber.

This policy provides periodic payments. Accrued claims will be paid within 30 days, and any balance remaining unpaid when liability terminates will be paid immediately on receipt of due written proof of loss.

Benefits covered by this Policy will be paid to the subscriber, except Moda Health will pay amounts due directly to a provider upon a member's written request. By paying benefits directly to a provider, Moda Health is relieved of the obligation to pay, and of any liability for paying, those benefits to the subscriber. Payment due at the time of a subscriber's death will be paid in accordance with the beneficiary designation or to the estate.

If the Texas Health and Human Services Commission pays covered expenses through medical assistance, the Texas Health and Human Services Commission is entitled to repayment by the Plan.

8.2.1 Explanation of Benefits (EOB)

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

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

8.2.2 Claim Inquiries

Customer Service can answer questions about how to file a claim, the status of a pending claim, or any action taken on a claim. The phone numbers are found in section 1.4.

8.3 LEGAL ACTIONS

Subscribers cannot bring any action at law or in equity for any benefits under the Plan until 60 days after filing a claim. No such action can be brought once 3 years have passed from the date the claim was required to have been filed.

8.4 THIRD-PARTY LIABILITY

A subscriber may have a legal right to recover benefits or healthcare costs from a third party as a result of a medical condition for which such costs were paid by Moda Health.

The Plan does not cover benefits for which a third party may be legally liable. Because recovery from a third party may be difficult and take a long time, as a service to the subscriber, Moda Health will pay a subscriber's expenses based on the understanding and agreement that Moda Health is entitled to be reimbursement from any recovery the subscriber may receive, no matter how the recovery is characterized.

Upon claiming or accepting benefits, or the provision of benefits, under the terms of the Plan, the subscriber agrees that Moda Health has the right to seek recovery for benefits we have paid. The subscriber agrees to do whatever is necessary to fully secure and protect, and to do nothing to prejudice, Moda Health's right of reimbursement or subrogation.

Moda Health is entitled to recovery equal to or the lesser of:

a. One-half of the subscriber's gross recovery
b. The total cost of benefits paid, provided or assumed by Moda Health that are the responsibility of the third party

If the subscriber is represented by an attorney, the amount Moda Health may recover is reduced by the amount of the attorney's fees and procurement costs under Section 140.007 of the Civil Practice and Remedies Code.

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

SECTION 9 MISCELLANEOUS PROVISIONS

9.1 WHEN MEDICARE IS SECONDARY

When Medicare becomes a secondary payer because of benefits from other plans or coverage, benefits payable under the Plan will be paid as if Medicare's normal Part A and Part B benefits had not been reduced.

9.2 NON-DUPLICATION OF BENEFITS

Services are eligible for only one type of benefit under the Plan. For example, if a service is defined as skilled nursing facility care, it is reimbursed under that benefit only.

9.3 EFFECT OF CHANGE OF PLAN

If on the effective date the subscriber has changed to the Plan from any other Moda Health supplement plan, no benefits will be paid under the Plan for any stay or care to the extent that benefits are paid under the prior plan.

9.4 GRACE PERIOD

Upon payment of the first premium, subscribers have 31 days after the premium due date to pay any subsequent required premium. Coverage under the Plan will stay in force until the end of this period. The premium must be paid for coverage in force during the grace period. If the Plan is replaced with any other health plan, coverage under the Plan will stop on the effective date of the new plan and the 31 day grace period will not apply.

9.5 VOLUNTARY TERMINATION

Subscribers wanting to terminate coverage under the Plan may do so after their initial renewal date by providing written notice to Moda Health in advance of the desired termination date. Coverage will end when we receive the notice or on the date requested in the notice. Any unearned premium will be returned. Claims incurred before the coverage end date will continue to be processed for payment according to the term of the Plan.

9.6 MEDICAID

Benefits and premiums under the Plan will be suspended during a subscriber's entitlement to benefits under Medicaid for up to 24 months. This suspension must be requested within 90 days of becoming eligible for Medicaid. If no longer entitled to Medicaid, coverage will be reinstated if the subscriber makes a request for reinstatement within 90 days of the date they are no longer entitled to Medicaid. Coverage may be reinstated as of the date Medicaid entitlement is lost if premiums due for that period are paid. If reinstatement is requested, the reinstated coverage:

a. Shall not require any new waiting period with respect to treatment of pre-existing conditions.
b. Shall provide coverage under the same plan (if available), or under a plan which provides substantially equivalent coverage.

9.7 MISSTATEMENT OF AGE

Misstating the subscriber's age at the time of enrollment may impact their coverage and benefits. If the subscriber's age was misstated and the policy would not have been issued had the correct age been known, the policy is void. Moda Health will refund all premiums paid under the policy.

9.8 RECOVERY OF CLAIMS PAID

If Moda Health makes a payment with respect to services and such payment is not required according to the terms of the Plan, Moda Health has the right to recover such payment from any of the following:

a. Any person to or for or with respect to whom the payments were made
b. Any insurance companies
c. Any other organization or person

9.9 CONFIDENTIALITY OF MEMBER INFORMATION

Keeping a subscriber's protected health information confidential is very important to Moda Health. Protected health information includes enrollment, claims, and medical and dental information. Moda Health uses such information internally for claims payment, referrals and authorization of services, and business operations such as case management and quality management programs. Moda Health does not sell this information. The Notice of Privacy Practices provides more detail about how Moda Health uses subscribers' information. A copy of the notice is available on the Moda Health website by following the HIPAA link or by calling Moda Health at 844-235-8012.

9.10 HOUSEHOLD PREMIUM DISCOUNT

Members are eligible for a household premium discount if they reside with at least one other Moda Health Medicare supplement member. The discount will be applied to at most three eligible members per household and may include the applicant's spouse, dependent, or other permanent resident of their home. The household discount will only be applicable if a Moda Health supplement policy is issued to each applicant. Moda Health may request additional documentation to determine eligibility.

The household premium discount will end if the other adult no longer resides in the home, including in the case of their death or moving to a nursing home. The discount will be removed effective the first of the following month.

9.11 REFUND OF PREMIUM

Moda Health will refund the appropriate portion of any unearned premium to you or your personal representative or estate in the case of your death, upon cancellation or termination of the policy before the end of its term.

9.12 INCONTESTABILITY

All statements made by the subscriber in a signed application for coverage are representations and not warranties. No statement made for the purpose of obtaining coverage will be used to void, cancel or non-renew their coverage unless it is a written document signed by the subscriber, a signed copy of which is furnished to the subscriber. After the second anniversary of the date the policy is issued, a misstatement, other than a fraudulent misstatement, made by the subscriber in the application for the policy may not be used to void the policy or to deny a claim for loss incurred or disability beginning after that anniversary.

9.13 CHANGE OF BENEFICIARY

Unless the subscriber makes an irrevocable designation of beneficiary, the right to change a beneficiary is reserved for the subscriber, and the consent of the beneficiary or beneficiaries is not required for the surrender or assignment of this policy, for any change of beneficiary or beneficiaries, or for any other changes in the policy.

9.14 TRANSFER OF BENEFITS

Only the subscriber is entitled to benefits under this policy. These benefits are not assignable or transferable to anyone else, except when assignment to a provider is requested in writing by the subscriber. Any other attempted assignment or transfer will not be binding on Moda Health,

except that Moda Health shall pay amounts due under the Plan directly to a provider when billed by a provider licensed, certified or otherwise authorized by laws in the state of Texas or upon the subscriber's written request.

Nondiscrimination notice

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

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

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

If you need any of the above, call:

888-217-2363 (TDD/TTY 711)

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

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

Scott White coordinates our nondiscrimination work:

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

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

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

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

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

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

modahealth.com/texas

moda HEALTH

Health plans provided by Moda Health Plan, Inc.

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

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

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

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

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

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

توجہ دیں: اگر آپ اردو (URDU) بولتے ہیں تو لسانی اعانت آپ کے لیے بلا معاوضہ دستیاب ہے۔ 1-877-605-3229 (TTY: 711) پر کال کریں

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

For help, call us directly at 844-235-8012.
(En español: 888-786-7461)

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