2025

Moda Health Medicare Supplement Plan

Plan F

If for any reason a subscriber decides not to purchase this policy, it may be returned 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.

Health plans provided by Moda Health Plan, Inc.

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.

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

This policy is authorized by the signature of Moda Health's Officer.

Scott Loftin

Senior Vice President Sales & Account Services

TABLE OF CONTENTS

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 required premium for the Plan is subject to change. Any change in premium will occur once in a 12-month period, and will apply to all subscribers insured under the Plan who reside in the state of Alaska. 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 and copayment amounts. When this happens, the Plan will automatically cover the changed amounts that are eligible for benefits.

At least 45 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 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, OR 97240

SECTION 2. DEFINITIONS

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.

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

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

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

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

Medical Emergency means the sudden and unexpected onset of symptoms, illness, injury or condition that would be deemed, under appropriate medical standards, to carry substantial risk of serious medical complication or permanent damage to the subscriber if care or services are withheld.

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

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

Medicare Part A Inpatient Hospital Deductible is the amount normally due from a 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.

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

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 F

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 F includes these additional benefits:

a. The Medicare Part A inpatient hospital deductible.

b. The Medicare Part B deductible.

c. 100% of Medicare Part B excess charges.

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

e. 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 Summary of Benefits for each covered confinement if the following conditions are met:

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

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 6. ELIGIBILITY

6.1 WHO IS ELIGIBLE FOR COVERAGE

Any person who is at least age 65 and an Alaska 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 Medicare Information Office in Anchorage 907-269-3680 or toll-free 800-478-6065.

6.2 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 7. CLAIMS ADMINISTRATION & PAYMENT

7.1 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

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.

7.1.1 Out-of-Country or 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, if there is no assignment of benefits

7.2 PAYMENT OF CLAIM

Benefits payable under the Plan will be paid to whoever received the Medicare benefits. Foreign travel emergency care benefits will be payable directly to the subscriber unless the member requests assignment of benefits to the provider. The provider must follow the claim filing process described in Section 7.1.

Sometimes a provider from a foreign country will require a member, at the time of discharge or treatment, to pay charges for a service. If this happens, the member must pay these amounts if they wish to accept the service. Moda Health will reimburse the member directly if any of the charges paid are later determined to be covered by the Plan.

7.2.1 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 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 7.1.

7.2.2 Time Frames for Processing Claims

For claims that do not require additional information, Moda Health will pay or deny the claim, and an EOB with an explanation of the payment will be sent to the member within 30 days after receiving the claim.

If additional information is needed to complete processing of the claim, a notice will be sent describing the information needed and the party responsible for providing the additional information will have 45 days to submit it. Once the additional information is received, processing of the claim will be completed within 15 days of receipt of the information or 30 days of the original receipt of the claim. If a claim is not completed timely, interest of 15% annually will accrue until processing of the claim is complete. Submission of information necessary to process a claim is also subject to the Plan's claim submission period explained in section 7.1.

7.2.3 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. The phone numbers are found in section 1.4.

7.3 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.

7.4 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. Moda Health will only seek to recover amounts a subscriber has received from third parties to the extent those amounts exceed full compensation to the subscriber for the injuries, losses or damages.

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 reimbursement from any recovery the subscriber may receive in excess of full compensation for the loss, 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 remedies and rights as stated in this section. Moda Health may elect to seek recovery under one or more of the procedures outlined in this section. 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 as discussed in this section.

7.4.1 Definitions

For purposes of section 7.4, the following definitions apply:

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

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 the subscriber. 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 subscriber including uninsured motorist coverage, under-insured motorist coverage, premises med-pay coverage, personal injury protection (PIP) coverage, and workers' compensation insurance.

Third Party Claim means any claim, lawsuit, settlement, award, verdict, judgment, arbitration decision or other action against a third party (or any right to such an action) by or on behalf of a subscriber, regardless of how the claims or damages or recovery funds are characterized. (For example, a subscriber who has received payment of medical expenses from Moda Health may file a third party claim against the party responsible for the subscriber's injuries, but only seek the recovery of non-economic damages. In that case, Moda Health is still entitled to recover benefits as described in section 7.4.)

7.4.2 Subrogation

Upon payment by the Plan, Moda Health shall be subrogated to all of the subscriber's rights of recovery. The subscriber shall do whatever is necessary to secure such rights and do nothing to prejudice them.

Moda Health may pursue the third party in its own name, or in the name of the subscriber. Moda Health is entitled to all subrogation rights and remedies under the common and statutory law, as well as under the Plan.

7.4.3 Right of Recovery

In addition to its subrogation rights, Moda Health may, at its option, ask that the subscriber, and their attorney, if any, protect its reimbursement rights. The following rules apply to this right of recovery:

a. The subscriber holds any rights of recovery against the third party in trust for Moda Health, but only for the amount of benefits Moda Health paid for that medical condition.

b. Moda Health is entitled to receive the amount of benefits it has paid for that medical condition out of any settlement or judgment which results from exercising the right of recovery against the third party. This is so regardless of whether the third party admits liability or asserts that the subscriber is also at fault. In addition, Moda Health is entitled to receive the amount of benefits it has paid whether the health care expenses are itemized or expressly excluded in the third party recovery.

c. If Moda Health asks the subscriber, and their attorney, to protect its reimbursement rights under this section, then the subscriber 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. Moda Health may ask the subscriber to sign an agreement to abide by the terms of this section. Moda Health will not be required to pay benefits for the medical condition until the agreement is properly signed and returned.

e. 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.

7.4.4 Motor Vehicle Accidents

Any expense for injury or illness that results from a motor vehicle accident and is payable under a motor vehicle insurance policy is not a covered benefit under the Plan and will not be paid by Moda Health.

If a claim for healthcare expenses arising out of a motor vehicle accident is filed with Moda Health, and if motor vehicle insurance has not yet paid, then Moda Health may advance benefits, subject to the rights and remedies outlined in sections 7.4.2 and 7.4.3.

7.4.5 Additional Third Party Liability Provisions

Subscribers shall comply with the following and agree that Moda Health may do one or more the following:

a. The subscriber and their representatives shall have the obligation 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 subscriber is seeking recovery of benefits paid by Moda Health from the third party.

b. The subscriber shall cooperate with Moda Health to protect its recovery rights under this section, including by:

   i. Signing and delivering such documents Moda Health reasonably requires to protect its rights, including a Third Party Reimbursement Questionnaire and Agreement. If the subscriber 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 this section, including all information available to the subscriber, or any representative or attorney representing the subscriber, 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 subscriber has this responsibility even if the first request for payment of benefits is a bill or invoice submitted to Moda Health by the subscriber's provider
   iv. Taking such actions as Moda Health may reasonably request to assist Moda Health in enforcing its rights to be reimbursed from third party recoveries.

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

d. The subscriber agrees that Moda Health may notify any third party, or third party's representatives or insurers, of its recovery rights set forth in section 7.4.

e. Even without the subscriber's written authorization, Moda Health may release to, or obtain from, any other insurer, organization or person, any information it needs to carry out reimbursement from third party recoveries and the provisions of section 7.4.

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

g. If the subscriber continues to receive medical treatment for a medical condition after obtaining a settlement or recovery from a third party, Moda Health will provide benefits for the continuing treatment of that medical condition only to the extent that the subscriber can establish that any sums that may have been recovered from the third party for the continuing medical treatment have been exhausted.

h. If the subscriber or the subscriber's representatives fail to do any of the above mentioned acts, then Moda Health has the right to not advance payment of benefits 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 or prior authorization of payment of benefits that all payments have been suspended, and may not be paid.

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

SECTION 8. MISCELLANEOUS PROVISIONS

8.1 CESSATION OF MEDICARE BENEFITS

This Plan will terminate if a subscriber ceases to be insured under either Part A or Part B of Medicare.

8.2 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.

8.3 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.

8.4 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.

8.5 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.

8.6 REINSTATEMENT

If any renewal premiums are not paid within the time allowed for payment, a subsequent acceptance of premiums by Moda Health or by any agent authorized by Moda Health to accept such premiums shall be subject to an application for reinstatement and a conditional receipt will be issued for the premiums received. The policy will be reinstated upon approval of such application by Moda Health or, lacking such approval, upon the 45th day following the date of the conditional receipt unless Moda Health has previously notified the subscriber in writing of its disapproval of the application. The reinstatement policy only covers claims resulting from an

accidental injury sustained after the date of reinstatement and claims due to sickness beginning more than 10 days after the reinstatement date. In all other respects the subscriber and Moda Health shall have the same rights as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions added in connection with the reinstatement. Any premiums accepted in connection with a reinstatement shall be applied to a period for which premiums have not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

8.7 VOLUNTARY TERMINATION

Subscribers wanting to terminate coverage under the Plan must provide written notice to Moda Health 30 days in advance of the desired termination date.

8.8 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 shall provide coverage under the same plan (if available), or under a plan which provides substantially equivalent coverage.

8.9 MISSTATEMENT OF AGE

Misstating the subscriber's age at time of enrollment may impact their coverage, premium and benefits. If the subscriber's age was misstated, all amounts payable under this policy shall be that which the premium paid would have purchased at the correct age.

8.10 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 initiate recovery of the payment within 365 days of the date the original payment was made 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.

Moda Health will give the party 30 calendar days written notice prior to recovering a payment. The party has the right to challenge the recovery.

8.11 ENTIRE POLICY

The application with Moda Health and this document plus any declaration pages, addendums, endorsements or amendments are the entire policy between the parties. No promises, terms, conditions or obligations exist other than those contained in the contract. No change in this policy shall be valid until approved by an executive officer of Moda Health and unless the approval is endorsed or attached to this policy. No agent has authority to change this policy or to waive any of its provisions. This document plus such declaration pages, addendums, endorsements or amendments, if any, shall supersede all other communications, representations or agreements, either verbal or written between the parties.

8.12 CONFIDENTIALITY OF MEMBER INFORMATION

The confidentiality of the subscriber's protected health information is of extreme importance to Moda Health. Protected health information includes, but is not limited to enrollment, claims, and medical and dental information. Moda Health uses such information internally for claims payment, referrals and authorization of services, and business operations such as case management and quality management programs. Moda Health does not sell this information. The Notice of Privacy Practices provides more 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 toll free at 855-425-4192.

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:

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

Medicaid Customer Service,
888-788-9821 (TDD/TTY 711)

Customer Service for all other plans,
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

2688-NDS-MH+DD-Generic (01/24)

ModaAKMedSupFbk 1-1-2025

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, ການຊ່ວຍເຫຼືອດ້ານພາສາແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ເສັຽຄ່າ. 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: 844-235-8012)

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