




The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, contact Moda Health at [www.modahealth.com](http://www.modahealth.com) or by calling 1-866-923-0409. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-888-217-2363 to request a copy.

Important Questions	Answers	Why This Matters:
<p><b>What is the overall <a href="#">deductible</a>?</b></p>	<p>For <a href="#">network providers</a> \$2,000 coordinated care individual / \$2,100 non-coordinated care individual / \$6,300 family; for <a href="#">out-of-network providers</a> \$4,000 individual / \$12,600 family.</p>	<p>Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p>
<p><b>Are there services covered before you meet your <a href="#">deductible</a>?</b></p>	<p>Yes. For coordinated care members, in-network primary care visits, office visits, urgent care visit, acupuncture, spinal manipulation, naturopathic substances and biofeedback are covered before you meet your <a href="#">deductible</a>.                      For all members, in-network breastfeeding support, chemical dependency services, outpatient mental health office visits, tobacco cessation treatment, and most <a href="#">preventive care</a> as well as in and out of network prescription medication and breastfeeding supplies are covered before you meet your <a href="#">deductible</a>.</p>	<p>This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a>. See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<p><b>Are there other <a href="#">deductibles</a> for specific services?</b></p>	<p>No.</p>	<p>You don't have to meet <a href="#">deductibles</a> for specific services.</p>
<p><b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b></p>	<p>For <a href="#">network providers</a> \$6,800 coordinated care individual / 7,200 non-coordinated care individual / \$21,600 family; for <a href="#">out-of-network providers</a> \$13,700 individual / \$27,400 family.                      Maximum cost share for <a href="#">network providers</a> \$7,900 individual / \$15,800 family.</p>	<p>The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a>, they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.</p>
<p><b>What is not included in the <a href="#">out-of-pocket limit</a>?</b></p>	<p><a href="#">Premiums</a>, <a href="#">balance-billing</a> charges, transplants and bariatric surgery not performed at Center of Excellence facilities, out-of-pocket expenses in excess of the reference price for an oral appliance or hip and knee replacements, and health care this <a href="#">plan</a> doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.modahealth.com">www.modahealth.com</a> or call 1-866-923-0409 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider		Out-of-Network Provider (You will pay the most)	
		Coordinated Care (You will pay the least)	Non-Coordinated Care		
If you visit a health care <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	\$30 <a href="#">copay</a> /visit, no <a href="#">deductible</a> for PCP 360 and \$50 <a href="#">copay</a> /visit, no <a href="#">deductible</a> for other providers	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$30 <a href="#">copay</a> /visit, no <a href="#">deductible</a> for acupuncture, spinal manipulation and naturopathic physicians; \$50 <a href="#">copay</a> /visit, no <a href="#">deductible</a> for other services.	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Includes office visits by chiropractors, naturopathic physicians and acupuncturists. \$2,000 plan year maximum for acupuncture care, spinal manipulation and naturopathic substances. <a href="#">Prior authorization</a> is required for some spinal manipulation and acupuncture services. Failure to obtain <a href="#">prior authorization</a> results in denial.
	<a href="#">Preventive care/screening/immunization</a>	No charge for most services. \$30 <a href="#">copay</a> /visit or 25% <a href="#">coinsurance</a> for remaining services. No <a href="#">deductible</a> for most services.	No charge for most services. 25% <a href="#">coinsurance</a> for remaining services.	50% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for. A list of in-network preventive services not subject to cost sharing can be viewed at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider		Out-of-Network Provider (You will pay the most)	
		Coordinated Care (You will pay the least)	Non-Coordinated Care		
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge for services at Quest Labs. 25% <a href="#">coinsurance</a> for other providers.	No charge for services at Quest Labs. 25% <a href="#">coinsurance</a> for other providers.	50% <a href="#">coinsurance</a>	Includes other tests such as EKG, allergy testing and sleep study. Some services require a \$100 <a href="#">copay</a> .
	Imaging (CT/PET scans, MRIs)	\$100 <a href="#">copay</a> , then 25% <a href="#">coinsurance</a>	\$100 <a href="#">copay</a> , then 25% <a href="#">coinsurance</a>	\$100 <a href="#">copay</a> , then 50% <a href="#">coinsurance</a>	<a href="#">Prior authorization</a> is required for many services. Failure to obtain <a href="#">prior authorization</a> results in denial
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.modahealth.com/pdl">www.modahealth.com/pdl</a>	Value tier	\$4 <a href="#">copay</a> /retail, \$8 <a href="#">copay</a> /mail-order, and \$12 <a href="#">copay</a> /Choice 90 prescription	\$4 <a href="#">copay</a> /retail, \$8 <a href="#">copay</a> /mail-order, and \$12 <a href="#">copay</a> /Choice 90 prescription	\$4 <a href="#">copay</a> /retail prescription	No <a href="#">deductible</a> . Prescription <a href="#">copay</a> and <a href="#">coinsurance</a> apply to the maximum cost share.
	Select tier	\$12 <a href="#">copay</a> /retail, \$24 <a href="#">copay</a> /mail-order, and \$36 <a href="#">copay</a> /Choice 90 prescription	\$12 <a href="#">copay</a> /retail, \$24 <a href="#">copay</a> /mail-order, and \$36 <a href="#">copay</a> /Choice 90 prescription	\$12 <a href="#">copay</a> /retail prescription	Covers up to a 31-day supply (retail prescriptions); up to a 90-day supply (participating Choice 90 pharmacies) and 90 day supply (mail-order prescription). <a href="#">Prior authorization</a> may be required. Mail order at Moda designated mail order pharmacy only.
	Preferred tier	25% <a href="#">coinsurance</a> : up to \$75 maximum retail; up to \$150 maximum mail-order; and up to \$225 maximum Choice 90 prescription	25% <a href="#">coinsurance</a> : up to \$75 maximum retail; up to \$150 maximum mail-order, and up to \$225 maximum Choice 90 prescription	25% <a href="#">coinsurance</a> , up to \$75 maximum retail prescription	Covers up to a 31-day supply specialty. <a href="#">Prior authorization</a> may be required. Moda designated pharmacy only. Specialty medications may include specialty tier and other tier medications that are often used to treat complex chronic health conditions.
	Nonpreferred tier	50% <a href="#">coinsurance</a> : up to \$175 maximum retail; up to \$450 maximum mail-order; and up to \$525 maximum Choice 90 prescription	50% <a href="#">coinsurance</a> : up to \$175 maximum retail; up to \$450 maximum mail-order; and up to \$525 maximum Choice 90 prescription	50% <a href="#">coinsurance</a> , up to \$175 maximum retail prescription	High-cost generic and non-preferred medications are excluded unless a formulary exception is requested and approved.  Anticancer medication is covered at no charge for in-network providers.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider		Out-of-Network Provider (You will pay the most)	
		Coordinated Care (You will pay the least)	Non-Coordinated Care		
	Specialty tier	25% <a href="#">coinsurance</a> up to \$200 maximum for preferred prescription, 50% <a href="#">coinsurance</a> up to \$500 maximum for non-preferred prescription	25% <a href="#">coinsurance</a> up to \$200 maximum for preferred prescription, 50% <a href="#">coinsurance</a> up to \$500 maximum for non-preferred prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Prior authorization</a> may be required. Failure to obtain <a href="#">prior authorization</a> results in denial.
	Physician/surgeon fees	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$100 <a href="#">copay</a> /visit, then 25% <a href="#">coinsurance</a>	\$100 <a href="#">copay</a> /visit, then 25% <a href="#">coinsurance</a>	\$100 <a href="#">copay</a> /visit, then 25% <a href="#">coinsurance</a>	<a href="#">Copay</a> waived if hospital admission immediately follows. Plan <a href="#">deductible</a> and <a href="#">coinsurance</a> may apply to some services. In-network <a href="#">deductible</a> and <a href="#">out-of-pocket limit</a> applies.
	<a href="#">Emergency medical transportation</a>	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	In-network <a href="#">deductible</a> and <a href="#">out-of-pocket limit</a> apply.
	<a href="#">Urgent care</a>	\$50 <a href="#">copay</a> /visit, no <a href="#">deductible</a>	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>
If you have a hospital stay	Facility fee (e.g., hospital room)	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Prior authorization</a> is required. Failure to obtain <a href="#">prior authorization</a> results in denial.
	Physician/surgeon fees	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider		Out-of-Network Provider (You will pay the most)	
		Coordinated Care (You will pay the least)	Non-Coordinated Care		
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$30 <a href="#">copay</a> , no <a href="#">deductible</a> for office visits and substance abuse services. 25% <a href="#">coinsurance</a> for other services.	\$30 <a href="#">copay</a> , no <a href="#">deductible</a> for office visits and substance abuse services. 25% <a href="#">coinsurance</a> for other services.	50% <a href="#">coinsurance</a>	<a href="#">Prior authorization</a> is required for some services. Failure to obtain <a href="#">prior authorization</a> results in denial.
	Inpatient services	\$30 <a href="#">copay</a> , no <a href="#">deductible</a> for substance abuse services. 25% <a href="#">coinsurance</a> for other services.	\$30 <a href="#">copay</a> , no <a href="#">deductible</a> for substance abuse services. 25% <a href="#">coinsurance</a> for other services.	50% <a href="#">coinsurance</a>	<a href="#">Prior authorization</a> is required. Failure to obtain <a href="#">prior authorization</a> results in denial.
<b>If you are pregnant</b>	Office visits	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	In-network elective abortion is covered at no cost sharing. <a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Plan year maximum of 140 visits.
	<a href="#">Rehabilitation services</a>	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Plan year maximum of 30 days for inpatient and 30 sessions for outpatient rehabilitation except as required for mental health parity. May be eligible for additional days or sessions for acute head or spinal cord injury. Habilitation services are limited to services that qualify under rehabilitation guidelines and medically necessary to treat a mental health condition. <a href="#">Prior authorization</a> may be required. Failure to obtain <a href="#">prior authorization</a> results in denial.
	<a href="#">Habilitation services</a>	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Plan year maximum of 60 visits

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider		Out-of-Network Provider (You will pay the most)	
		Coordinated Care (You will pay the least)	Non-Coordinated Care		
If you need help recovering or have other special health needs	<a href="#">Durable medical equipment</a>	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Includes supplies and prosthetics. Frequency limits apply to some DME. <a href="#">Prior authorization</a> may be required. Failure to obtain <a href="#">prior authorization</a> results in denial.
	<a href="#">Hospice services</a>	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Not covered	Preventive vision screening for children age 3-5 covered in-network at no cost sharing. Eye exams are not covered for other ages.
	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	Not covered	None

#### Excluded Services & Other Covered Services:

<b>Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a>.)</b>		
<ul style="list-style-type: none"> <li>• Cosmetic Surgery, except as required for certain situations</li> <li>• Dental Care (Adult) except for accident related injuries</li> </ul>	<ul style="list-style-type: none"> <li>• Long Term Care</li> <li>• Private Duty Nursing</li> </ul>	<ul style="list-style-type: none"> <li>• Routine Eye Care (Adult)</li> <li>• Routine Foot Care, except for diabetes</li> <li>• Weight Loss Programs, except for WW</li> </ul>
<b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)</b>		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric Surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic Care</li> <li>• Hearing Aids</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility Treatment</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or <http://www.dol.gov/ebsa/healthreform> for group health coverage subject to ERISA, the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov) for non-federal governmental group health plans, and the Oregon Division of Financial Regulation at 1-888-877-4894 or [www.dfr.oregon.gov](http://www.dfr.oregon.gov) for Church plans. Other coverage options may be available to you too, including

buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Moda Health at 1-866-923-0409. For group health coverage subject to ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your appeal. Contact the Oregon Division of Financial Regulation at 1-888-877-4894 or [www.dfr.oregon.gov](http://www.dfr.oregon.gov).

**Does this plan provide Minimum Essential Coverage? Yes.**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet Minimum Value Standards? Yes.**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 888-786-7461.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 888-873-1395.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 888-873-1395.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 888-873-1395.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*—————

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,000
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">coinsurance</a>	25%
■ Other <a href="#">coinsurance</a>	25%

#### This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$40
Coinsurance	\$2,600
What isn't covered	
Limits or exclusions	\$300
<b>The total Peg would pay is</b>	<b>\$4,940</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,000
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">coinsurance</a>	25%
■ Other <a href="#">coinsurance</a>	25%

#### This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,900
Copayments	\$600
Coinsurance	\$900
What isn't covered	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$3,460</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,000
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">coinsurance</a>	25%
■ Other <a href="#">coinsurance</a>	25%

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$300
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,800</b>



# Moda does not discriminate

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

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

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

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

888-217-2363 (TDD/TTY 711)

## **If you think we did not offer these services or discriminated, you can file a written complaint.**

### **Please mail or fax it to:**

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

## **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](http://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](http://hhs.gov/ocr/office/file/index.html).

## **Dave Nessler-Cass coordinates our nondiscrimination work:**

Dave Nessler-Cass,  
Chief Compliance Officer  
601 SW Second Ave.  
Portland, OR 97204  
855-232-9111  
[compliance@modahealth.com](mailto:compliance@modahealth.com)

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).

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）

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)

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)

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

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

ATANSYON: Si ou pale Kreyòl Ayisyen, nou ofri sèvis gratis pou ede w nan lang ou pale a. Rele nan 1-877-605-3229 (moun ki itilize sistèm TTY rele : 711)

ATTENTION : si vous êtes locuteurs francophones, le service d'assistance linguistique gratuit est disponible. Appelez au 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)

ATENÇÃO: Caso fale português, estão disponíveis serviços gratuitos de ajuda linguística. Telefone para 1-877-605-3229 (TERMINAL: 711)

ATTENZIONE: Se parla italiano, sono disponibili per lei servizi gratuiti di assistenza linguistica. Chiamare il numero 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（TTY、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。

Achtung: Falls Sie Deutsch sprechen, stehen Ihnen kostenlos Sprachassistenzen zur Verfügung. Rufen sie 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.

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)

โปรดทราบ: หากคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี โทร 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.