




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 1-888-873-1395. 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 1-888-873-1395 to request a copy.

| Important Questions   | Answers   | Why This Matters:  |
|---|---|--|
| <p>What is the overall <a href="#">deductible</a>?</p>                                | <p>For <a href="#">network providers</a> \$500 individual / \$1,000 family; for <a href="#">out-of-network providers</a> \$1,000 individual / \$2,000 family</p>  | <p>Generally, you must pay all of the costs from <a href="#">providers</a> 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>Are there services covered before you meet your <a href="#">deductible</a>?</p>    | <p>Yes. In-network primary care, <a href="#">specialist</a>, <a href="#">urgent care</a>, virtual care, outpatient mental health and chemical dependency, outpatient <a href="#">rehabilitation</a> and <a href="#">habilitation</a>, outpatient diagnostic x-rays and labs, acupuncture, massage therapy, spinal manipulation, children's dental check-up services, and most <a href="#">preventive care</a> as well as in and out-of-network value, select, preferred and non-preferred prescription medications, children's routine eye exams and glasses, and hearing aid services 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>Are there other <a href="#">deductibles</a> for specific services?</p>             | <p>No.</p>  | <p>You don't have to meet <a href="#">deductibles</a> for specific services.</p>   |
| <p>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</p> | <p>For <a href="#">network providers</a> \$6,750 individual / \$13,500 family; for <a href="#">out-of-network providers</a> \$13,500 individual / \$27,000 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>What is not included in the <a href="#">out-of-pocket limit</a>?</p>               | <p><a href="#">Premiums</a>, <a href="#">balance-billing</a> charges, penalties for failure to obtain pre-authorization 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 1-888-873-1395 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 <a href="#">plan's 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<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most) |   |
| If you visit a health care <a href="#">provider's office</a> or clinic | Primary care visit to treat an injury or illness        | \$30 <a href="#">copay</a> /office visit, \$20 <a href="#">copay</a> /virtual care visit; <a href="#">deductible</a> does not apply   | 50% <a href="#">coinsurance</a>                    | Includes office visits by naturopaths. No charge for virtual care visit with CirrusMD.  |
|  | <a href="#">Specialist</a> visit                        | \$30 <a href="#">copay</a> for acupuncture, massage therapy and spinal manipulation visits, \$20 <a href="#">copay</a> /virtual care visit, \$60 <a href="#">copay</a> / for other services; <a href="#">deductible</a> does not apply. | 50% <a href="#">coinsurance</a>                    | Includes office visits by acupuncturists and chiropractors. Hearing services covered at 20% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply. Spinal manipulation, massage therapy and acupuncture are each limited to 24 visits per year. No charge for virtual care visit with CirrusMD. <a href="#">Prior authorization</a> may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500. |
|  | <a href="#">Preventive care/screening</a> /immunization | No charge for most services, \$30 <a href="#">copay</a> /visit or 20% <a href="#">coinsurance</a> for remaining services; <a href="#">deductible</a> does not apply for most services.  | 50% <a href="#">coinsurance</a>                    | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.   |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.modahealth.com](http://www.modahealth.com).

| Common Medical Event   | Services You May Need   | What You Will Pay   |   | Limitations, Exceptions, & Other Important Information   |
|--|---|---|---|--|
|  |   | Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most)                                    |  |
| If you have a test   | <a href="#">Diagnostic test</a><br>(x-ray, blood work)  | 20% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply in outpatient/office setting                                  | 50% <a href="#">coinsurance</a>   | Includes other tests such as EKG, allergy testing and sleep study.<br><br><a href="#">Prior authorization</a> may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.  |
|  | Imaging (CT/PET scans, MRIs)  | 20% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>   |  |
| If you need drugs to treat your illness or condition<br>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  | No charge   | No charge   | Covers up to a 90-day supply for retail and mail order prescriptions. One copay for each 30-day supply. Mail order at a Moda Health designated mail order pharmacy only. <a href="#">Prior authorization</a> may be required.  |
|  | Select tier   | \$20 <a href="#">copay</a> /prescription, <a href="#">deductible</a> does not apply.  | \$20 <a href="#">copay</a> /prescription, <a href="#">deductible</a> does not apply.  |  |
|  | Preferred tier  | \$40 <a href="#">copay</a> /prescription, <a href="#">deductible</a> does not apply.  | \$40 <a href="#">copay</a> /prescription, <a href="#">deductible</a> does not apply.  | Covers up to a 30-day supply for most specialty medications. <a href="#">Prior authorization</a> may be required. Moda Health designated specialty pharmacy only.<br><br>Anticancer medication is covered at the standard <a href="#">coinsurance</a> rate for <a href="#">in-network</a> and <a href="#">out-of-network providers</a> . |
|  | Non-preferred tier  | \$115 <a href="#">copay</a> /prescription, <a href="#">deductible</a> does not apply.   | \$115 <a href="#">copay</a> /prescription, <a href="#">deductible</a> does not apply. |  |
| <a href="#">Specialty tier</a>   | 20% <a href="#">coinsurance</a> preferred specialty prescription.<br>50% <a href="#">coinsurance</a> nonpreferred specialty prescription. | Not covered   |   |  |
| If you have outpatient surgery   | Facility fee (e.g., ambulatory surgery center)  | 20% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>   | <a href="#">Prior authorization</a> may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.  |
|  | Physician/surgeon fees  | 20% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>   |  |
| If you need immediate medical attention  | <a href="#">Emergency room care</a>   | \$250 <a href="#">copay</a> /visit, then 20% <a href="#">coinsurance</a>  | \$250 <a href="#">copay</a> /visit, then 20% <a href="#">coinsurance</a>              | <a href="#">Copay</a> waived if hospital admission immediately follows. <a href="#">In-network deductible</a> and <a href="#">out-of-pocket limit</a> apply.   |
|  | <a href="#">Emergency medical transportation</a>  | 20% <a href="#">coinsurance</a>   | 20% <a href="#">coinsurance</a>   | Commercial transportation is limited to one-way for a sudden, life-endangering medical condition. <a href="#">In-network deductible</a> and <a href="#">out-of-pocket limit</a> apply.   |
|  | <a href="#">Urgent care</a>   | \$60 <a href="#">copay</a> /office visit,<br>\$20 <a href="#">copay</a> /virtual care visit;<br><a href="#">deductible</a> does not apply | 50% <a href="#">coinsurance</a>   | No charge for virtual care visit with CirrusMD.  |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.modahealth.com](http://www.modahealth.com).

| Common Medical Event  | Services You May Need                     | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information  |
|---|---|--|--|---|
|   |   | Network Provider<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most) |   |
| If you have a hospital stay   | Facility fee (e.g., hospital room)        | 20% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>                    | <a href="#">Prior authorization</a> is required to avoid a penalty of 50% up to a maximum deduction of \$2,500.   |
|   | Physician/surgeon fees                    | 20% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>                    |   |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | \$30 <a href="#">copay</a> /office visit, \$20 <a href="#">copay</a> /virtual care visit; <a href="#">deductible</a> does not apply.   | 50% <a href="#">coinsurance</a>                    | Psychological or neuropsychological testing limited to 12 hours per year. No charge for virtual care visit with CirrusMD.   |
|   | Inpatient services                        | 20% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>                    | <a href="#">Prior authorization</a> is required for inpatient and residential services to avoid a penalty of 50% up to a maximum deduction of \$2,500.  |
| If you are pregnant   | Office visits                             | 20% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>                    | <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copay</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 | 20% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>                    |   |
|   | Childbirth/delivery facility services     | 20% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>                    |   |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>          | 20% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>                    | Calendar year maximum of 130 visits.  |
|   | <a href="#">Rehabilitation services</a>   | \$60 <a href="#">copay</a> /outpatient visit, <a href="#">deductible</a> does not apply. 20% <a href="#">coinsurance</a> for inpatient | 50% <a href="#">coinsurance</a>                    | Calendar year maximum of 30 days for inpatient and 45 sessions for outpatient rehabilitation and habilitation. Limits apply separately to outpatient rehabilitative and habilitative services. Limits apply separately to rehabilitative and habilitative services. <a href="#">Prior authorization</a> may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500. |
|   | <a href="#">Habilitation services</a>     | \$60 <a href="#">copay</a> /outpatient visit, <a href="#">deductible</a> does not apply. 20% <a href="#">coinsurance</a> for inpatient | 50% <a href="#">coinsurance</a>                    |   |
|   | <a href="#">Skilled nursing care</a>      | 20% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>                    | Calendar year maximum of 60 visits  |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.modahealth.com](http://www.modahealth.com).

| Common Medical Event   | Services You May Need                     | What You Will Pay  |   | Limitations, Exceptions, & Other Important Information  |
|--|---|--|---|---|
|  |   | Network Provider<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most)  |   |
| If you need help recovering or have other special health needs | <a href="#">Durable medical equipment</a> | 20% <a href="#">coinsurance</a><br><br>20% <a href="#">coinsurance</a> for hearing aids, <a href="#">deductible</a> does not apply.  | 50% <a href="#">coinsurance</a><br><br>20% <a href="#">coinsurance</a> for hearing aids, <a href="#">deductible</a> does not apply. | Includes supplies and prosthetics. Frequency limits apply to some DME. Hearing aids are subject to a \$3,000 limit per 3-year period. <a href="#">Prior authorization</a> may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.                 |
|  | <a href="#">Hospice services</a>          | 20% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>   |   |
| If your child needs dental or eye care                         | Children's eye exam                       | No charge  | 50% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply   | Limited to one eye exam per calendar year. Additional <a href="#">in-network</a> preventive eye screening for children age 3-5 at no cost sharing. Eye exams for age 19 and over covered at \$10 <a href="#">copay</a> /visit, <a href="#">deductible</a> does not apply. |
|  | Children's glasses                        | No charge  | 50% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply   | Coverage limited to one pair of glasses per calendar year for children under age 19. For age 19 and over, see member handbook for vision limits.  |
|  | Children's dental check-up                | No charge for preventive and diagnostic services, 20% <a href="#">coinsurance</a> , for basic and major dental services, 50% <a href="#">coinsurance</a> , for orthodontia | 50% <a href="#">coinsurance</a>   | For members under age 19. Frequency limits apply to some services.  |

#### Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- |                         |  |                        |
|-------------------------|--|------------------------|
| • Bariatric surgery     | • Long-term care                                     | • Private-duty nursing |
| • Cosmetic surgery      | • Naturopathic substances                            | • Routine foot care    |
| • Dental care (Adult)   | • Non-emergency care when traveling outside the U.S. | • Weight loss programs |
| • Infertility treatment |  |                        |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- |               |                     |                            |
|---------------|---------------------|----------------------------|
| • Abortion    | • Chiropractic care | • Hearing aids             |
| • Acupuncture |                     | • Routine eye care (Adult) |

**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, the Alaska Division of Insurance at 1-800-467-8725 or <http://www.commerce.state.ak.us/ins/Insurance/consumer.html> 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 on how 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 1-888-873-1395 or the Alaska Division of Insurance at <http://www.commerce.state.ak.us/ins/Insurance/consumer.html> or 1-800-467-8725. 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).

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

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this plan meet the 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 [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$60
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$500          |
| <a href="#">Copayments</a>        | \$10           |
| <a href="#">Coinsurance</a>       | \$2,400        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$50           |
| <b>The total Peg would pay is</b> | <b>\$2,960</b> |

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$60
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a> *     | \$200          |
| <a href="#">Copayments</a>        | \$1,300        |
| <a href="#">Coinsurance</a>       | \$20           |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,540</b> |

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$60
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a> *     | \$500          |
| <a href="#">Copayments</a>        | \$500          |
| <a href="#">Coinsurance</a>       | \$300          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,300</b> |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

# Nondiscrimination notice

**We follow 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:**

888-374-8906 (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:**

Delta Dental of Oregon and Alaska  
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 Nesseler-Cass coordinates our nondiscrimination work:**

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

Dental plans in Oregon provided by Oregon Dental Service, dba Delta Dental Plan of Oregon. Dental plans in Alaska provided by Delta Dental of Alaska. 60667319 (6/20)



Delta Dental of Oregon & Alaska



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 (الهاتف النصي: 711) 1-877-605-3229

بولتے ہیں تو سانی (URDU) توجہ دیں: اگر آپ اردو امانت آپ کے لیے بلا معاوضہ دستیاب ہے۔ پر کال کریں 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).

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

توجہ: در صورتی کہ بہ فارسی صحبت می کنید، خدمات ترجمہ بہ صورت رایگان برای شما موجود است۔ با (TTY: 711) 1-877-605-3229 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 Sprachassistentendienste 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 (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。

अगत्यनुं: 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

ໂບດຊາບ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການຊ່ວຍເຫຼືອດ້ານພາສາແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ຄ່າສິ້ຍຄ່າ. 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 servicii 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 គឺមានផ្តល់ជូនណែនាំអ្នក។ 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 คุณสามารถใช้บริการช่วยเหลือด้านภาษาได้ ฟรี 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 totagia. Vala'au i le 1-877-605-3229 (TTY: 711)

IPANGAG: Nu agsasaoka iti llocano, 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)

