



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 1-855-425-4543. 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 1-855-425-4543 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	For Tier I (Salem Health Hospitals & Clinics and facilities): None; for Tier II (Connexus network): \$500 individual / \$1,000 family; for Tier III (Connexus network): \$750 individual / \$1,500 family; most <a href="#">out-of-network providers</a> are not covered. Services by Tier IV <a href="#">providers</a> apply to Tier III <a href="#">deductible</a> .	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> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. Examples of some services: Tier II and Tier III <a href="#">preventive care</a> , most urgent care facility charges, office visits for outpatient mental health and substance use disorder, as well as Tier II and Tier III diabetes services, ambulance, and prescription medications are covered before you meet your <a href="#">deductible</a> .	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> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	For Tier I \$2,500 individual / \$5,000 family in a calendar year; for Tier II \$3,250 individual / \$6,500 family; for Tier III \$4,000 individual / \$8,000 family; most <a href="#">out-of-network providers</a> are not covered. Services by Tier IV <a href="#">providers</a> apply to Tier III <a href="#">out-of-pocket limit</a> .	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.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, expenses incurred due to brand substitution and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.modahealth.com">www.modahealth.com</a> or call 1-855-425-4543 for a list of <a href="#">network providers</a> .	You pay the least if you use a provider in Tier I (Salem Health Hospitals & Clinics and facilities). You pay more if you use a provider in Tier II or Tier III (Connexus network). 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 <a href="#">provider's</a> 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.

Important Questions	Answers	Why This Matters:
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
		Tier I Provider	Tier II Provider	Tier III Provider	Tier IV (Out-of-Network) Provider	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	No charge	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Not covered	None.
	<a href="#">Specialist</a> visit	No charge	\$20 <a href="#">copay</a> /visit, no <a href="#">deductible</a> for acupuncture, spinal manipulation and massage therapy 20% <a href="#">coinsurance</a> for all other visits and office services other than outpatient surgery and x-rays and lab tests	\$20 <a href="#">copay</a> /visit, no <a href="#">deductible</a> for acupuncture, spinal manipulation and massage therapy 40% <a href="#">coinsurance</a> for all other visits and office services other than outpatient surgery and x-rays and lab tests	40% <a href="#">coinsurance</a> , no <a href="#">deductible</a> for acupuncture, spinal manipulation and massage therapy Not covered for all other visits	Office visits by chiropractors, naturopathic physicians and acupuncturists are considered as specialist visits unless they are listed as PCPs in the network. 20 visits per calendar year maximum for acupuncture care. 20 visits per calendar year maximum for spinal manipulations. \$1,000 per calendar year maximum for massage therapy.
	<a href="#">Preventive care</a> / <a href="#">screening</a> / immunization	No charge	20% <a href="#">coinsurance</a> for tobacco supplies No charge for other services.	20% <a href="#">coinsurance</a> for tobacco supplies No charge for other services.	Not covered	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.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Not covered	Includes other tests such as EKG, allergy testing and sleep study. Some services may have a different <a href="#">copay</a> / <a href="#">coinsurance</a> .
	Imaging (CT/PET scans, MRIs)	No charge	20% <a href="#">coinsurance</a>	\$100 <a href="#">copay</a> /visit, then 40% <a href="#">coinsurance</a> outpatient 40% <a href="#">coinsurance</a> inpatient	Not covered	Some services may have a different <a href="#">copay</a> / <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.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier I Provider	Tier II Provider	Tier III (Out-of-Network) Provider	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="http://www.modahealth.com/pdl">prescription drug coverage</a> is available at <a href="http://www.modahealth.com/pdl">www.modahealth.com/pdl</a>	Value	\$2 <a href="#">copay</a> for 30-day supply retail / \$6 <a href="#">copay</a> for 90-day supply retail and mail order	\$2 <a href="#">copay</a> for 30-day supply retail No <a href="#">deductible</a>	\$2 <a href="#">copay</a> for 30-day supply retail No <a href="#">deductible</a>	Tier I - Salem Health and mail order pharmacies
	Select	25% <a href="#">coinsurance</a> \$5 minimum / \$25 maximum per prescription retail and mail order	35% <a href="#">coinsurance</a> , \$15 minimum / \$25 maximum per prescription retail No <a href="#">deductible</a>	50% <a href="#">coinsurance</a> \$15 minimum / no maximum per prescription retail No <a href="#">deductible</a>	Tier II - ArrayRx Core Network  Tier III – other retail pharmacies
	Preferred	30% <a href="#">coinsurance</a> \$5 minimum / \$75 maximum per prescription retail and mail order	40% <a href="#">coinsurance</a> , \$15 minimum / no maximum per prescription retail No <a href="#">deductible</a>	50% <a href="#">coinsurance</a> \$15 minimum / no maximum per prescription retail No <a href="#">deductible</a>	Covers Tier I retail and mail order - up to a 90-day supply per prescription; Tier II and Tier III retail - up to a 30-day supply per prescription. <a href="#">Prior authorization</a> may be required. Mail order at a Moda designated mail order pharmacy only.
	Non-Preferred	50% <a href="#">coinsurance</a> \$5 minimum / no maximum per prescription retail and mail order	50% <a href="#">coinsurance</a> , \$15 minimum / no maximum per prescription retail No <a href="#">deductible</a>	50% <a href="#">coinsurance</a> \$15 minimum / no maximum per prescription retail No <a href="#">deductible</a>	Covers up to a 30-day supply specialty. <a href="#">Prior authorization</a> may be required. Moda designated pharmacy only.
	Specialty	25% <a href="#">coinsurance</a> \$5 minimum / \$25 maximum for select 30% <a href="#">coinsurance</a> \$150 maximum per prescription for preferred; 50% <a href="#">coinsurance</a> for non-preferred	Not covered	Not covered	Cost Sharing for anticancer medication is same as any other medication.  \$85 maximum cost share 30-day supply and \$255 maximum cost share 90-day supply for insulin, <a href="#">deductible</a> does not apply.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier I Provider	Tier II Provider	Tier III Provider	Tier IV (Out-of-Network) Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Not covered	Additional Cost Tier services require a \$100 <a href="#">copay</a> or a \$500 <a href="#">copay</a> , then 40% <a href="#">coinsurance</a> for Tier II and Tier III. <a href="#">Prior authorization</a> may be required. Failure to get <a href="#">prior authorization</a> results in denial.
	Physician/surgeon fees	No charge	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Not covered	
If you need immediate medical attention	<a href="#">Emergency room care</a>	Facility fee: \$250 <a href="#">copay</a> /visit Provider fee: No charge	Facility fee: \$250 <a href="#">copay</a> /visit Provider fee: 20% <a href="#">coinsurance</a>	Facility fee: \$250 <a href="#">copay</a> /visit Provider fee: 20% <a href="#">coinsurance</a>	Facility fee: \$250 <a href="#">copay</a> /visit Provider fee: 20% <a href="#">coinsurance</a>	<a href="#">Copay</a> waived if hospital admission immediately follows.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a> , no <a href="#">deductible</a>	20% <a href="#">coinsurance</a> , no <a href="#">deductible</a>	20% <a href="#">coinsurance</a> , no <a href="#">deductible</a>	20% <a href="#">coinsurance</a> , no <a href="#">deductible</a>	None.
	<a href="#">Urgent care</a>	No charge for visits related to mental health/substance abuse; No charge for virtual care visits by Salem Health <a href="#">providers</a> ; \$20 <a href="#">copay</a> / visit for all other visits	No charge for visits related to mental health/substance abuse; \$40 <a href="#">copay</a> /visit, no <a href="#">deductible</a> for all other visits	No charge for visits related to mental health/substance abuse; \$50 <a href="#">copay</a> /visit for all other visits	No charge for visits related to mental health/substance abuse; 40% <a href="#">coinsurance</a> for all other visits	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Not covered	Additional Cost Tier services require a \$100 <a href="#">copay</a> or a \$500 <a href="#">copay</a> , then 40% <a href="#">coinsurance</a> for Tier II and Tier III. <a href="#">Prior authorization</a> is required for many services. Failure to obtain <a href="#">prior authorization</a> results in denial.
	Physician/surgeon fees	No charge	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Not covered	

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier I Provider	Tier II Provider	Tier III Provider	Tier IV (Out-of-Network) Provider	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	No charge for office visits 20% <a href="#">coinsurance</a> for other outpatient services.	No charge for office visits 20% <a href="#">coinsurance</a> for other outpatient services.	No charge for office visits 40% <a href="#">coinsurance</a> for other outpatient services.	Plan <a href="#">coinsurance</a> may apply to some services.
	Inpatient services	No charge	No charge for Residential Treatment Programs 20% <a href="#">coinsurance</a> for all other services	No charge for Residential Treatment Programs 20% <a href="#">coinsurance</a> for all other services	40% <a href="#">coinsurance</a>	<a href="#">Prior authorization</a> is required. Failure to obtain <a href="#">prior authorization</a> results in denial.
If you are pregnant	Office visits	No charge	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Not covered	<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	No charge	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Not covered	
	Childbirth/delivery facility services	No charge	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Not covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	Not covered	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Not covered	Calendar year maximum of 100 visits.
	<a href="#">Rehabilitation services</a>	No charge	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Not covered	Calendar year maximum of 60 visits each for physical therapy, occupational therapy and speech and hearing therapy except for treating mental health conditions. Services for neurodevelopmental disorders or developmental delays related to a neurogenic condition are covered. <a href="#">Prior authorization</a> may be required. Failure to obtain <a href="#">prior authorization</a> results in denial.
	<a href="#">Habilitation services</a>	No charge outpatient. Not covered inpatient.	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Not covered	

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier I Provider	Tier II Provider	Tier III Provider	Tier IV (Out-of-Network) Provider	
If you need help recovering or have other special health needs	<a href="#">Skilled nursing care</a>	N/A	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Not covered	Calendar year maximum of 120 days
	<a href="#">Durable medical equipment</a>	No charge	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Not covered	Includes supplies and prosthetics. <a href="#">Prior authorization</a> may be required. Failure to obtain <a href="#">prior authorization</a> results in denial.
	<a href="#">Hospice services</a>	No charge	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Not covered	None.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	No charge	40% <a href="#">coinsurance</a>	Preventive vision exam limited for children age 3-5. Eye exams are not covered for other ages.
	Children's glasses	Not covered	Not covered	Not covered	Not covered	None.
	Children's dental check-up	Not covered	Not covered	Not covered	Not covered	None

#### Excluded Services & Other Covered Services:

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> .)		
<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> <li>Infertility treatment (except for diagnostic visits)</li> </ul>	<ul style="list-style-type: none"> <li>Long-term care</li> <li>Naturopathic supplies</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>Private-duty nursing</li> <li>Routine eye care (Adult)</li> <li>Routine foot care, except for diabetes</li> <li>Weight loss programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>Abortion</li> <li>Acupuncture</li> </ul>	<ul style="list-style-type: none"> <li>Bariatric surgery</li> <li>Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids</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 1-855-425-4543. 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.**

[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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist coinsurance</a>	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$2,400

What isn't covered	
Limits or exclusions	\$50

<b>The total Peg would pay is</b>	<b>\$2,950</b>
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### 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>	\$500
■ <a href="#">Specialist coinsurance</a>	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$60
<a href="#">Coinsurance</a>	\$1,800

What isn't covered	
Limits or exclusions	\$20

<b>The total Joe would pay is</b>	<b>\$2,380</b>
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### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist coinsurance</a>	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$300

What isn't covered	
Limits or exclusions	\$0

<b>The total Mia would pay is</b>	<b>\$1,100</b>
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The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact your group administrator.



# 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.

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## **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

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

## **Scott White coordinates our nondiscrimination work:**

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

[modahealth.com](https://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. Health plans provided by Moda Health Plan, Inc. Individual medical plans in Alaska provided by Moda Assurance Company.



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