




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 1-844-776-1593. 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 1-844-776-1593 to request a copy.

| Important Questions   | Answers  | Why This Matters:   |
|---|--|---|
| <b>What is the overall <a href="#">deductible</a>?</b>                                | For <a href="#">network providers</a> \$350 individual / \$1,050 family; for <a href="#">out-of-network providers</a> \$600 individual / \$1,800 family  | 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> .  |
| <b>Are there services covered before you meet your <a href="#">deductible</a>?</b>    | Yes. Examples of some services: In-network <a href="#">preventive care</a> , chronic condition visits, e-visits, outpatient mental health, chemical dependency and diabetes services, maternity professional services, outpatient diagnostic x-rays and labs, self-administered chemo, nutritional therapy, breastfeeding support, and the first four primary care visits, as well as in and out of network hospice care, routine nursery care, diabetic supplies, and breastfeeding supplies are covered before you meet your <a href="#">deductible</a> . <a href="#">Copayments</a> do not count toward 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>             | Yes. \$50 individual / \$150 family for generic and brand prescription drugs.  | You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.  |
| <b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b> | For <a href="#">network providers</a> \$1,500 individual / \$4,500 family; for <a href="#">out-of-network providers</a> \$4,000 individual / \$12,000 family; \$1,000 individual / \$3,000 family for prescription drugs.<br>Maximum cost share: for <a href="#">network providers</a> \$6,850 individual / \$13,700 family  | 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, <a href="#">deductibles</a> , spinal manipulation and acupuncture, emergency care, imaging, infertility, hearing exam & aids, sleep studies, additional cost tier, non-essential health benefits, and <a href="#">copays</a> for <a href="#">out-of-network</a> surgery.   | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .   |

| 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/pebb">http://www.modahealth.com/pebb</a> or call 1-844-776-1593 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<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</a> office or clinic | Primary care visit to treat an injury or illness       | No cost sharing for chronic condition or E-visits.<br>No charge/CirrusMD virtual visit; \$10 <a href="#">copay</a> for other primary care visits, <a href="#">deductible</a> does not apply to first 4 visits | E-visits are not covered.<br>30% <a href="#">coinsurance</a> for other visits | If a member does not select and properly use a PCP 360, claims will be paid at a lower benefit level.   |
|  | <a href="#">Specialist</a> visit                       | \$10 <a href="#">copay</a> /visit   | 30% <a href="#">coinsurance</a>   | Includes office visits by chiropractors, naturopathic physicians and acupuncturists. Calendar year maximum of 12 visits for acupuncture and 20 visits for spinal manipulation. \$1,000 calendar year maximum for massage therapy. <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, \$10 <a href="#">copay</a> /visit for remaining services, <a href="#">deductible</a> does not apply.   | 30% <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.  |

| 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)   |   |
| <b>If you have a test</b>   | <a href="#">Diagnostic test</a> (x-ray, blood work) | No charge, <a href="#">deductible</a> does not apply for most services; \$100 <a href="#">copay</a> /visit for sleep studies. | 30% <a href="#">coinsurance</a> / \$100 <a href="#">copay</a> /visit and 30% <a href="#">coinsurance</a> for sleep studies | Includes other tests such as EKG, allergy testing and sleep study.  |
|   | Imaging (CT/PET scans, MRIs)                        | \$100 <a href="#">copay</a> /service  | \$100 <a href="#">copay</a> and 30% <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. Copay does not apply to cancer diagnosis and treatment.   |
| <b>If you need drugs to treat your illness or condition</b><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 drugs   | No cost sharing for retail or mail-order  | No cost sharing for retail prescription  | Covers up to a 30-day supply (retail pharmacy); and 90-day supply (mail-order and participating retail pharmacies). <a href="#">Prior authorization</a> may be required. Mail order at exclusive mail order pharmacy only.<br><br>Cost Sharing for self-administered chemotherapy medication is \$10 <a href="#">copay</a> for a 30-day supply. |
|   | Generic drugs                                       | \$10 <a href="#">copay</a> /retail, \$25 <a href="#">copay</a> /mail-order \$10 <a href="#">copay</a> /specialty              | \$10 <a href="#">copay</a> /retail prescription  |   |
|   | Brand drugs   | \$30 <a href="#">copay</a> /retail, \$75 <a href="#">copay</a> mail-order, \$100 <a href="#">copay</a> and specialty.         | \$30 <a href="#">copay</a> /retail prescription  |   |
| <b>If you have outpatient surgery</b>   | Facility fee (e.g., ambulatory surgery center)      | \$10 <a href="#">copay</a> /visit   | \$100 <a href="#">copay</a> and 40% <a href="#">coinsurance</a>  | <a href="#">Prior authorization</a> may be required. Failure to obtain <a href="#">prior authorization</a> results in denial. <a href="#">Out-of-network</a> bariatric surgery is not covered.  |
|   | Physician/surgeon fees                              | \$10 <a href="#">copay</a> /visit   | 30% <a href="#">coinsurance</a>  | <a href="#">Prior authorization</a> may be required. Failure to obtain <a href="#">prior authorization</a> results in denial. An additional \$100 or \$500 <a href="#">copay</a> is required for additional cost tier procedures.   |
| <b>If you need immediate medical attention</b>  | <a href="#">Emergency room care</a>                 | \$150 <a href="#">copay</a> /visit  | \$150 <a href="#">copay</a> /visit   | In-network <a href="#">deductible</a> and maximum cost share apply. <a href="#">Copay</a> waived if hospital admission immediately follows. Plan <a href="#">coinsurance</a> may apply to some services.  |
|   | <a href="#">Emergency medical transportation</a>    | \$75 <a href="#">copay</a> /trip  | \$75 <a href="#">copay</a> /trip   | None  |
|   | <a href="#">Urgent care</a>                         | \$25 <a href="#">copay</a> /visit, No charge/CirrusMD virtual visit   | \$25 <a href="#">copay</a> /visit  | None  |

| 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)   |  |
| <b>If you have a hospital stay</b>   | Facility fee (e.g., hospital room)        | \$50 <a href="#">copay</a> per day / \$250 <a href="#">copay</a> per admission   | \$500 <a href="#">copay</a> and 40% <a href="#">coinsurance</a>  | <a href="#">Prior authorization</a> is required. Failure to obtain <a href="#">prior authorization</a> results in denial. <a href="#">Out-of-network</a> bariatric surgery is not covered.   |
|  | Physician/surgeon fees                    | \$10 <a href="#">copay</a> /service  | 30% <a href="#">coinsurance</a>  | <a href="#">Prior authorization</a> is required. Failure to obtain <a href="#">prior authorization</a> results in denial. An additional \$100 or \$500 <a href="#">copay</a> is required for additional cost tier procedures.  |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | \$10 <a href="#">copay</a> /visit, <a href="#">deductible</a> does not apply   | 40% <a href="#">coinsurance</a> for non-mental health facility services, 30% <a href="#">coinsurance</a> for other services                              | No cost sharing for substance abuse services from <a href="#">network providers</a> .  |
|  | Inpatient services                        | \$50 <a href="#">copay</a> per day / \$250 <a href="#">copay</a> per admission   | \$500 <a href="#">copay</a> and 40% <a href="#">coinsurance</a> for inpatient mental health services, 40% <a href="#">coinsurance</a> for other services | <a href="#">Prior authorization</a> is required. Failure to obtain <a href="#">prior authorization</a> results in denial. No cost sharing for substance abuse services from <a href="#">network providers</a> .  |
| <b>If you are pregnant</b>   | Office visits                             | No charge, <a href="#">deductible</a> does not apply.  | 30% <a href="#">coinsurance</a>  | <a href="#">Cost sharing</a> does not apply to certain <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, <a href="#">deductible</a> does not apply.  | 30% <a href="#">coinsurance</a>  |  |
|  | Childbirth/delivery facility services     | \$50 <a href="#">copay</a> per day / \$250 <a href="#">copay</a> per admission   | \$500 <a href="#">copay</a> and 40% <a href="#">coinsurance</a>  |  |
| <b>If you need help recovering or have other special health needs</b>            | <a href="#">Home health care</a>          | \$10 <a href="#">copay</a> /visit  | 30% <a href="#">coinsurance</a>  | Calendar year maximum of 180 visits. <a href="#">Prior authorization</a> is required. Failure to obtain <a href="#">prior authorization</a> results in denial.   |
|  | <a href="#">Rehabilitation services</a>   | \$10 <a href="#">copay</a> /visit outpatient; \$50 <a href="#">copay</a> per day / \$250 <a href="#">copay</a> per admission for inpatient | 30% <a href="#">coinsurance</a> for outpatient; 40% <a href="#">coinsurance</a> for inpatient  | Calendar year maximum of 30 days for inpatient and 60 sessions for outpatient rehabilitation except as required for mental health parity. May be eligible for 60 days for inpatient rehabilitation for acute head or spinal cord injury or treatment of a stroke. <a href="#">Habilitation services</a> 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>     | \$10 <a href="#">copay</a> /visit outpatient; \$50 <a href="#">copay</a> per day / \$250 <a href="#">copay</a> per admission for inpatient | 30% <a href="#">coinsurance</a> for outpatient; 40% <a href="#">coinsurance</a> for inpatient  |  |

| 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)   |  |
|  | <a href="#">Skilled nursing care</a>      | \$50 <a href="#">copay</a> per day / \$250 <a href="#">copay</a> per admission for inpatient | 40% <a href="#">coinsurance</a>                      | Calendar year maximum of 180 days  |
| If you need help recovering or have other special health needs | <a href="#">Durable medical equipment</a> | 15% <a href="#">coinsurance</a>  | 30% <a href="#">coinsurance</a>                      | Includes supplies and prosthetics. No cost sharing for diabetic supplies or insulin. <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, <a href="#">deductible</a> does not apply   | No charge, <a href="#">deductible</a> does not apply | None   |
| If your child needs dental or eye care                         | Children's eye exam                       | No charge, <a href="#">deductible</a> does not apply   | Not covered  | Preventive eye exam limited to in-network for children age 3-5. Eye exams are not covered for other ages.  |
|  | Children's glasses                        | Not covered  | Not covered  | None   |
|  | Children's dental check-up                | 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> </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> <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 Weight Watchers)</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> <li>Infertility Treatment</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 1-844-776-1593. 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.

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*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](#) \$350
- [Specialist copayment](#) \$10
- Hospital (facility) [copayment](#) \$50
- Other [coinsurance](#) 15%

**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>               |              |
|-----------------------------------|--------------|
| Deductibles                       | \$350        |
| Copayments                        | \$100        |
| Coinsurance                       | \$0          |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$50         |
| <b>The total Peg would pay is</b> | <b>\$500</b> |

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$350
- [Specialist copayment](#) \$10
- Hospital (facility) [copayment](#) \$50
- Other [coinsurance](#) 15%

**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>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$300          |
| Copayments                        | \$1,000        |
| Coinsurance                       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,320</b> |

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$350
- [Specialist copayment](#) \$10
- Hospital (facility) [copayment](#) \$50
- Other [coinsurance](#) 15%

**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>               |              |
|-----------------------------------|--------------|
| Deductibles                       | \$350        |
| Copayments                        | \$400        |
| Coinsurance                       | \$40         |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$790</b> |

# 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:**

888-217-2363 (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](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)



