




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 1-888-217-2363. 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>What is the overall <a href="#">deductible</a>?</p>	<p>For <a href="#">network providers</a> \$2,500 individual / \$5,000 family; for <a href="#">out-of-network providers</a> \$10,000 individual / \$20,000 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>Are there services covered before you meet your <a href="#">deductible</a>?</p>	<p>Yes. In-network primary care visits, office visits, urgent care visit, outpatient rehabilitation, outpatient mental health and chemical dependency services, outpatient diabetes services, biofeedback, breastfeeding support, pediatric vision care, and most <a href="#">preventive care</a>, as well as in and out of network routine nursery care, prescription drugs, 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>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> \$5,850 individual / \$11,700 family; for <a href="#">out-of-network providers</a> \$29,400 individual / \$58,800 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>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, 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 1-888-217-2363 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 (You will pay the least)	Out-of-Network Provider (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	\$40 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$70 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	Includes office visits by chiropractors, naturopaths and acupuncturists.
	<a href="#">Preventive care/screening/immunization</a>	No charge for most services. \$40 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply, or 30% <a href="#">coinsurance</a> for remaining services	Not covered for most services. 50% <a href="#">coinsurance</a> for some services.	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> .
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Includes other tests such as EKG, allergy testing and sleep study.
	Imaging (CT/PET scans, MRIs)	30% <a href="#">coinsurance</a>	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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p><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></p>	Value tier	\$15 <a href="#">copay</a> /retail prescription, \$45 <a href="#">copay</a> /mail-order prescription	\$15 <a href="#">copay</a> /retail prescription	Covers up to a 30-day supply (retail prescriptions); 90 day supply (mail-order prescription). <a href="#">Prior authorization</a> may be required. Mail order at exclusive mail order pharmacy only. <a href="#">Deductible</a> does not apply.
	Select tier	\$15 <a href="#">copay</a> /retail prescription, \$45 <a href="#">copay</a> /mail-order prescription	\$15 <a href="#">copay</a> /retail prescription	
	Preferred tier	\$50 <a href="#">copay</a> /retail prescription, \$150 <a href="#">copay</a> /mail-order prescription	\$50 <a href="#">copay</a> /retail prescription	Covers up to a 30-day supply specialty. Prior authorization may be required. Exclusive pharmacy only. Specialty medications may include specialty tier and other tier medications that are often used to treat complex chronic health conditions.
	Brand tier	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	Specialty tier	50% <a href="#">coinsurance</a>	Not covered	
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	30% <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	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
<p><b>If you need immediate medical attention</b></p>	<a href="#">Emergency room care</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	In-network <a href="#">deductible</a> and <a href="#">out-of-pocket limit</a> apply.
	<a href="#">Emergency medical transportation</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	In-network <a href="#">deductible</a> and <a href="#">out-of-pocket limit</a> apply.
	<a href="#">Urgent care</a>	\$70 <a href="#">copay</a> /visit, <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	None
<p><b>If you have a hospital stay</b></p>	Facility fee (e.g., hospital room)	30% <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	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
<p><b>If you need mental health, behavioral health, or substance abuse services</b></p>	Outpatient services	\$40 <a href="#">copay</a> /office visit; <a href="#">deductible</a> does not apply, and 30% <a href="#">coinsurance</a> for other outpatient services	50% <a href="#">coinsurance</a>	None
	Inpatient services	30% <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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Includes elective abortion services rendered by a licensed and certified professional provider. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. <a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> .
	Childbirth/delivery professional services	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	30% <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>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Calendar year maximum of 140 visits for <a href="#">out-of-network providers</a> .
	<a href="#">Rehabilitation services</a>	\$40 <a href="#">copay</a> /visit outpatient, <a href="#">deductible</a> does not apply. 30% <a href="#">coinsurance</a> inpatient	50% <a href="#">coinsurance</a>	Calendar year maximum of 30 days for inpatient and 30 sessions for outpatient rehabilitation and habilitation. Limits apply separately to rehabilitative and habilitative services. <a href="#">Prior authorization</a> may be required. Failure to obtain <a href="#">prior authorization</a> results in denial.
	<a href="#">Habilitation services</a>	\$40 <a href="#">copay</a> /visit outpatient, <a href="#">deductible</a> does not apply. 30% <a href="#">coinsurance</a> inpatient	50% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Calendar year maximum of 60 visits
	<a href="#">Durable medical equipment</a>	30% <a href="#">coinsurance</a> ; 67% <a href="#">coinsurance</a> for wigs	50% <a href="#">coinsurance</a> ; 67% <a href="#">coinsurance</a> for wigs	Includes supplies and prosthetics. Wheelchairs subject to frequency limits. <a href="#">Prior authorization</a> may be required. Failure to obtain <a href="#">prior authorization</a> results in denial.
	<a href="#">Hospice services</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Hospice coverage includes respite care limits of 5 consecutive days and a lifetime maximum of 30 days

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge, <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	Limited to one eye exam per calendar year for children under age 19. Additional in-network preventive eye screening for children age 3-5 at no cost sharing.
	Children's glasses	No charge, <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	Covers one pair of glasses per calendar year, under age 19.
	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>Acupuncture</li> <li>Bariatric Surgery</li> <li>Chiropractic Care</li> <li>Cosmetic Surgery, except as required for certain situations</li> </ul>	<ul style="list-style-type: none"> <li>Dental Care except for accident related injuries</li> <li>Infertility Treatment</li> <li>Long Term Care</li> <li>Naturopathic Substances</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>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/contactEBSA/consumerassistance.html>, Oregon Division of Financial Regulation at 1-888-877-4894 or [www.dfr.oregon.gov](http://www.dfr.oregon.gov), and Oregon health insurance marketplace or SHOP at [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 1-888-217-2363. 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>	\$2,500
■ <a href="#">Specialist copayment</a>	\$70
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

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:

<i>Cost Sharing</i>	
Deductibles	\$2,500
Copayments	\$40
Coinsurance	\$3,000
<i>What isn't covered</i>	
Limits or exclusions	\$300
<b>The total Peg would pay is</b>	<b>\$5,840</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>	\$2,500
■ <a href="#">Specialist copayment</a>	\$70
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

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:

<i>Cost Sharing</i>	
Deductibles	\$1,860
Copayments	\$1,400
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$3,320</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>	\$2,500
■ <a href="#">Specialist copayment</a>	\$70
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

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:

<i>Cost Sharing</i>	
Deductibles	\$1,530
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,730</b>

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.

# Moda Health nondiscrimination notice

**Moda, Inc. complies with applicable federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability or sex.**

Moda provides free, timely aids and services to people with disabilities to help them communicate with us effectively. These accommodations include sign language interpreters and written information in other formats.

If your primary language is not English, Moda also provides free, timely interpretation services and/or materials written in other languages.

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## **If you need any of the services listed above, contact:**

Customer Service,  
888-217-2363 (TDD/TTY 711)

## **If you believe that Moda has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a written grievance by mailing or faxing it to:**

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

## **If you need assistance filing a grievance, 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 to:

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).

Office for Civil Rights complaint forms are available at [hhs.gov/ocr/office/file/index.html](http://hhs.gov/ocr/office/file/index.html).

## **Moda's efforts to assure nondiscrimination are coordinated by:**

Tom Bikales, VP Legal Affairs  
601 SW Second Ave.  
Portland, OR 97204  
855-232-9111  
[compliance@modahealth.com](mailto:compliance@modahealth.com)

Health plans in Oregon and Alaska provided by Moda Health Plan, Inc. 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. 15019019 (8/16)



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).

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 مجاناً. 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 Sprachassistentendienste 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.



Delta Dental of Oregon & Alaska

