



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 PAI at 1-800-768-4375 or visit www.paisc.com. 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.paisc.com or call 1-800-768-4375 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For TH providers \$1,500 individual/ \$3,000 family. For <u>network providers</u> \$3,000 individual / \$6,000 family. For <u>out-of-network providers</u> \$4,500 individual / \$9,000 family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . HRA dollars may be used to offset <u>deductible</u> expenses.
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> , <u>primary</u> and <u>specialist care</u> and <u>prescription drugs</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	For TH providers \$4,000 individual/ \$8,000 family. For <u>network providers</u> \$8,000 individual / \$16,000 family. For <u>out-of-network providers</u> \$9,000 individual / \$18,000 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , penalties, <u>balance-billing</u> charges and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.tidelandshealthplan.com or call 1-800-498-6693 for a list of <u>network providers</u> .	This <u>plan</u> uses a provider network. You pay the least if you use a TH <u>provider</u> . You pay more if you use a network <u>provider</u> . You will pay the most if you use an <u>out-of-network provider</u> and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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
		Tidelands Health (You will pay the least)	Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	<u>Primary care</u> visit to treat an injury or illness	\$25 <u>copay</u> /visit, <u>deductible</u> does not apply.	\$50 <u>copay</u> /visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	Includes <u>primary care</u> visits for mental/behavioral health and substance abuse services. Telehealth/Telemedicine is covered at Tidelands and In-Network providers.
	<u>Specialist</u> visit	\$50 <u>copay</u> /visit, <u>deductible</u> does not apply.	\$100 <u>copay</u> /visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	Telehealth/Telemedicine is covered at Tidelands and In-Network providers.
	<u>Preventive care/screening/immunization</u>	No charge	No charge	50% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for. Only flu shots, mammograms and certain women's evidence-informed services are covered at an out of network provider.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$25 <u>copay</u> /visit, <u>deductible</u> does not apply.	\$50 <u>copay</u> /visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	Tidelands \$50 <u>copay</u> /visit, <u>deductible</u> does not apply. <u>Coinurance</u> after <u>deductible</u> if not billed with office visit for Network and Out-of-Network only. Co-pay may apply for physician office visit.
	Imaging (CT/PET scans, MRIs)	15% <u>coinsurance</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	MRI requires <u>pre-authorization</u> . 50% reduction in benefit if not obtained.



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
		Tidelands Health (You will pay the least)	Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.proactrx.com or call 877-635-9545.	Generic drugs	\$5 <u>copay</u> /prescription (31 day supply); \$12.50 <u>copay</u> /prescription (90 day supply); <u>deductible</u> does not apply to <u>prescription drugs</u>	\$25 <u>copay</u> /prescription (31 day supply); \$25 <u>copay</u> /prescription (90 day supply); <u>deductible</u> does not apply to <u>prescription drugs</u>	Not Covered	Certain medications are not covered under the plan; however, similar alternative medications are available – contact ProAct for assistance
	Preferred brand drugs	\$35 <u>copay</u> /prescription (31 day supply); \$50 <u>copay</u> /prescription (90 day supply); <u>deductible</u> does not apply to <u>prescription drugs</u>	\$55 <u>copay</u> /prescription (31 day supply); \$75 <u>copay</u> /prescription (90 day supply); <u>deductible</u> does not apply to <u>prescription drugs</u>	Not Covered	90 day supplies are available through a Tidelands Health Family pharmacy (at both Tidelands Health locations) or the ProAct mail order program.
	Non-preferred brand drugs	\$60 <u>copay</u> /prescription (31 day supply); \$80 <u>copay</u> /prescription (90 day supply); <u>deductible</u> does not apply to <u>prescription drugs</u>	\$80 <u>copay</u> /prescription (31 day supply); \$110 <u>copay</u> /prescription (90 day supply); <u>deductible</u> does not apply to <u>prescription drugs</u>	Not Covered	Certain brand medications are free through Tidelands Health Cana Rx. Learn more at www.tidelandshealthcanarx.com
	<u>Specialty drugs</u>	30% <u>coinsurance</u> up to \$150 maximum at Family pharmacy.	30% <u>coinsurance</u> up to \$300 maximum at CVS and Walgreens. 30% <u>coinsurance</u> up to \$200 maximum at all other retail pharmacies.	Not Covered	<u>Deductible</u> does not apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% <u>coinsurance</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Pre-authorization</u> required. 50% reduction in benefit if not obtained.
	Physician/surgeon fees	15% <u>coinsurance</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	None

 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
		Tidelands Health (You will pay the least)	Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	15% <u>coinsurance</u>	15% <u>coinsurance</u>	15% <u>coinsurance</u>	None.
	<u>Emergency medical transportation</u>	15% <u>coinsurance</u>	15% <u>coinsurance</u>	15% <u>coinsurance</u>	None
	<u>Urgent care</u>	15% <u>coinsurance</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	15% <u>coinsurance</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Pre-authorization</u> is required. Failure to obtain <u>pre-authorization</u> will result in zero benefits payable by the plan. Penalty applies to all providers.
	Physician/surgeon fees	15% <u>coinsurance</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% <u>coinsurance</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Inpatient services	15% <u>coinsurance</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Pre-authorization</u> is required. Failure to obtain <u>pre-authorization</u> will result in zero benefits payable by the plan. Penalty applies to all providers.

 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
		Tidelands Health (You will pay the least)	Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	15% <u>coinsurance</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply to certain <u>preventive services</u>. Depending on the type of services, a <u>copayment</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). <u>Pre-authorization</u> is required. Failure to obtain <u>pre-authorization</u> will result in zero benefits payable by the plan. Penalty applies to all providers.
	Childbirth/delivery professional services	15% <u>coinsurance</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	15% <u>coinsurance</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	15% <u>coinsurance</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Pre-authorization</u> is required. Failure to obtain <u>pre-authorization</u> will result in zero benefits payable by the plan. Penalty applies to all providers.
	<u>Rehabilitation services</u>	15% <u>coinsurance</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Pre-authorization</u> is required. Failure to obtain <u>pre-authorization</u> will result in zero benefits payable by the plan. Penalty applies to all providers.
	<u>Habilitation services</u>	15% <u>coinsurance</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Pre-authorization</u> is required. Failure to obtain <u>pre-authorization</u> will result in zero benefits payable by the plan. Penalty applies to all providers.
	<u>Skilled nursing care</u>	15% <u>coinsurance</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Pre-authorization</u> is required. Failure to obtain <u>pre-authorization</u> will result in zero benefits payable by the plan. Penalty applies to all providers.
	<u>Durable medical equipment</u>	15% <u>coinsurance</u>	15% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Hospice services</u>	15% <u>coinsurance</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Pre-authorization</u> is required. Failure to obtain <u>pre-authorization</u> will result in zero benefits payable by the plan. Penalty applies to all providers.

 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
		Tidelands Health (You will pay the least)	Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	Not covered
	Children's glasses	Not covered	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	Not covered	Not covered

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.)

- | | | |
|---|---|---|
| <ul style="list-style-type: none"> • Acupuncture • Chiropractic care • Cosmetic surgery • Dental care | <ul style="list-style-type: none"> • Hearing aids • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • Routine eye care • Routine foot care • Weight loss programs |
|---|---|---|

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

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| <ul style="list-style-type: none"> • Bariatric surgery (at Tidelands Health providers only) | <ul style="list-style-type: none"> • Private-duty nursing |
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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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform/ / Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323x61565 or www.cciio.cms.gov/ / Planned Administrators Inc. at 1-800-768-4375 or visit www.paisc.com. 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 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 the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform/ / Planned Administrators Inc. at 1-800-768-4375 or visit www.paisc.com or you can contact your employer's human resources department at 1-843-652-1008.

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 1-800-768-4375.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-768-4375.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-768-4375.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-768-4375.

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 <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist copayment</u>	\$50
■ Hospital (facility) <u>coinsurance</u>	15%
■ Other <u>coinsurance</u>	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*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,500
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,060

Managing Joe's type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist copayment</u>	\$50
■ Hospital (facility) <u>coinsurance</u>	15%
■ Other <u>coinsurance</u>	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*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$1,300
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,420

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist copayment</u>	\$50
■ Hospital (facility) <u>coinsurance</u>	15%
■ Other <u>coinsurance</u>	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*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$200
<u>Coinsurance</u>	100
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,800

Coverage examples calculated based on services being rendered by a Tidelands Health provider. Coverage examples listed do not include HRA dollars you may receive from Tidelands Health. HRA dollars are earned based on completion of wellness activities in the prior plan year. These HRA dollars funded by Tidelands Health help reduce the amount you have to pay out of pocket for deductibles, co-pays and coinsurance.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Discrimination is Against the Law

Planned Administrators, Inc. (PAI) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination under Section 1557 of the Patient Protection and Affordable Care Act). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

We provide people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats).

We provide free language assistance services to people whose primary language is not English, which may include:

- Qualified interpreters
- Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our Section 1557 Coordinator at 1-800-832-9686 or by emailing Section1557Coordinator@hcrcompliance.com.

If you believe that we have 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 grievance by emailing Section1557Coordinator@hcrcompliance.com or by calling 1-800-832-9686. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, email Section1557Coordinator@hcrcompliance.com and assistance will be provided.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services 200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

This notice is available at PAI's website: <https://www.paisc.com>.

Foreign Language Access

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice (TDD: 711). Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥 1-844-396-0188。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đỡ với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건강보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187로 연락해 주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839. (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعدُه أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions à propos de ce plan médical, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 1-844-396-0190. (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره ی این برنامه ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)

Ni da doodago t'áá háída bíká'aná nilwo'ígíí díí Béeso Ách'ááh naa'nilígi háá'ída yí na' ídíl kidgo, nihá'áhóót'i' nihí ká'a'doo wołgo kwii ha'át'íshíí bí na'ídołkidígi doo bik'é'azláagóó. Ata' halne'é ła' bich'í' ha desdizh nínízingo, koji' béesh bee hólne' 1-844-516-6328. (Navajo)

Vann du adda ebbah es du am helfa bisht, enniichi questions hend veyyich *deah health plan*, hend diah's recht fa hilf un information greeya in eiyah aykni shprohch unni kosht. Fa shvetza mitt en interpreter, roof deah nummah oh 1-833-584-1829. (Pennsylvania Dutch)