**This 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 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, call **833-584-1828.** 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 **https://www.healthcare.gov/sbc-glossary** or **www.cciio.cms.gov** or call **833-584-1828** to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | Tier 1 provider:**$2,000** individual / **$3,000** per family member / **$4,000** family total<br>Tier 2 provider:**$2,000** individual / **$3,000** per family member / **$4,000** family total<br>Non-preferred provider: **$2,000** individual / $**3,000** per family member/**$4,000** family total | This is a high deductible health plan which means you must pay all the costs, except for preventive care, from providers up to the deductible amount before this plan begins to pay. With an embedded family deductible, the plan begins to make payments for a family member as soon as that family member has reached his/her per family member deductible of $3,000. Then the family total deductible can be met with combined expenses from all family members. |
| **Are there services covered before you meet your deductible?** | Yes. In-network (Tier 1 and Tier 2) preventive care are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers preventive services with Tiers 1 and 2 providers without cost-sharing and before you meet your deductible. See a list of covered Preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | Tier 1 provider:**$4,000** individual / **$8,000** family<br>Tier 2 provider: **$4,000** individual / **$8,000** family<br>Non-preferred provider: **$6,000** individual / **$12,000** family | The individual out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges, pre-authorization penalties, and health care services this plan doesn't cover. | Even though you may pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. See **https:www.MyHealthToolkitCapital.com** or call **1-800-810-BLUE (2583)** for a list of In-network providers (Tier 1 and Tier 2). | This plan uses a provider network. You may pay the least if you use a Tier 1 provider. You may pay more if you use a Tier 2 provider. You may pay the most if you use a non-preferred provider and you may receive a bill from the provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware that your Tier 1 or Tier 2 provider might use a non-preferred provider for some services such as lab work. Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

Capital Blue Cross is an independent licensee of the BlueCross BlueShield Association.(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration Date: 5/31/2022) (HHS - OMB control NA AB20220419175309485533

⚠ 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 1 (You may pay the least) | Tier 2 (You may pay more) | Non-Preferred Provider (You may pay the most) | |
| **If you visit a health care provider's office or clinic** | Personal family physician visit to treat an injury or illness (in-person or virtual) | After Deductible<br>$20 Copay/visit | After Deductible<br>$20 Copay/visit | After Deductible<br>40% Coinsurance | e-Visits are covered at all tiers.<br>Penn Medicine OnDemand virtual urgent primary care at Tier 1 only (see SPD for copay details).<br>Tier 1 & Tier 2 allergy injections are covered with 10% coinsurance.<br>Dialysis is only covered at Tier 1 & Tier 2 with 10% coinsurance. |
| | Specialist visit | After Deductible<br>$35 Copay/visit | After Deductible<br>$35 Copay/visit | After Deductible<br>40% Coinsurance | Second surgical opinions are covered as specialist visits. |
| | Preventive care/ screening/immunization | No Charge | No Charge | After Deductible<br>40% Coinsurance | See www.healthcare.gov for preventive care guidelines. There may be additional benefits available. See your Employer for details. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (outpatient) (x-ray, blood work) | After Deductible<br>No Charge | After Deductible<br>No Charge | After Deductible<br>40% Coinsurance | Independent Lab / X-Ray is only available under Tiers 2 and 3. |
| | Imaging (outpatient) (CT/PET scans, MRIs) | After Deductible<br>No Charge | After Deductible<br>10% Coinsurance | After Deductible<br>40% Coinsurance | Pre-authorization may apply unless Tier 1 provider. |

| Common Medical Event | Services You May Need | What You Will Pay | | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|---|
| | | Pharmacy | | Mail Order | | |
| | | CP (You may pay the least) | Other (You may pay more) | CP (You may pay the least) | Postal Prescription Services (You may pay more) | |
| If you need drugs to treat your illness or condition<br><br>More information about prescription drug coverage is available at www.liviniti.com<br>**CP = LG Health Convenience Pharmacy** | Generic Drugs | After Deductible $5 Copay | After Deductible $15 Copay | After Deductible $10 Copay | After Deductible $30 Copay | Copayment applicable after annual deductible (individual and/or family) applies.<br><br>Covers up to a 30-day supply Retail drugs or 31-90 day supply Mail-Order prescription.<br><br>Copay does not apply to preventive drugs required by the Affordable Care Act. |
| | Generic Hypertension Drugs | After Deductible $0 Copay | After Deductible $15 Copay | After Deductible $0 Copay | | |
| | Generic Hyperlipidemia Drugs | After Deductible $0 Copay | After Deductible $15 Copay | After Deductible $0 Copay | | |
| | Preferred Brand Name Drugs | After Deductible $15 Copay | After Deductible $45 Copay | After Deductible $30 Copay | After Deductible $90 Copay | |
| | Non-preferred Brand Name Drugs | After Deductible $30 Copay | After Deductible $75 Copay | After Deductible $60 Copay | After Deductible $150 Copay | |
| | Specialty Drugs | After Deductible $0 Copay | Not Covered | | | |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Tier 1 (You may pay the least) | Tier 2 (You may pay more) | Non-Preferred Provider (You may pay the most) | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | After Deductible No Charge | After Deductible No Charge | After Deductible 40% Coinsurance | Bariatric surgery and related services at Lancaster General Health (LGH) covered at 100%. Bariatric Surgery at Tier 2 providers covered at $2,500 copay after 10% coinsurance. Non-preferred provider not covered. Pre-authorization required. |
| | Physician/surgeon fees | After Deductible No Charge | After Deductible No Charge | After Deductible 40% Coinsurance | None |
| **If you need immediate medical attention** | Emergency room care | After Deductible 20% Coinsurance | After Deductible 20% Coinsurance | After Deductible 20% Coinsurance | None |
| | Emergency medical transportation | After Deductible 10% Coinsurance | After Deductible 10% Coinsurance | After Deductible 10% Coinsurance | None |
| | Urgent care | After Deductible 10% Coinsurance | After Deductible 10% Coinsurance | After Deductible 10% Coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | After Deductible 10% Coinsurance | After Deductible 10% Coinsurance $5,000 copay may apply for certain inpatient stays | After Deductible 40% Coinsurance | Pre-authorization is required. If you don't get pre-authorization for non-preferred provider hospitalization, benefits will be reduced by $500 of the total cost of the service.<br><br>$5,000 copay may apply for certain Tier 2 non-emergent hospitalizations. |
| | Physician/surgeon fees | After Deductible 10% Coinsurance | After Deductible 10% Coinsurance | After Deductible 40% Coinsurance | 10% coinsurance for Tier 1 and Tier 2 anesthesiologists, radiologists and pathologists. 40% coinsurance for non-preferred anesthesiologists, radiologists and pathologists. |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Tier 1 (You will pay the least) | Tier 2 (You may pay more) | Non-Preferred Provider (You will pay the most) | |
| **If you need mental health, behavioral health, or substance use disorder services** | Mental/behavioral health outpatient services | After Deductible $20 Copay/visit | After Deductible $20 Copay/visit | After Deductible 40% Coinsurance | Telehealth visits $15 Copay for Tier 1 and Tier 2 providers after deductible.<br><br>Telehealth visits 40% coinsurance for non-preferred providers after deductible. |
| | Substance use disorder outpatient services | After Deductible $20 Copay/visit | After Deductible $20 Copay/visit | After Deductible 40% Coinsurance | |
| | Mental/behavioral health inpatient professional services | After Deductible 10% Coinsurance | After Deductible 10% Coinsurance | After Deductible 40% Coinsurance | Pre-authorization is required. If you don't get pre-authorization for non-preferred provider hospitalization benefits will be reduced by $500 of the total cost of the service.<br><br>Additional costs apply for inpatient hospitalization. Refer to "If you have a hospital stay" for facility fees.<br><br>$5,000 copay may apply for certain Tier 2 non-emergent hospitalizations. |
| | Substance use disorder inpatient professional services | After Deductible 10% Coinsurance | After Deductible 10% Coinsurance | After Deductible 40% Coinsurance | |
| **If you are pregnant** | Office visits | After Deductible $20 Copay/visit | After Deductible $20 Copay/visit | After Deductible 40% Coinsurance | Pre-authorization is required. If you don't get pre-authorization for non-preferred provider hospitalization, benefits will be reduced by $500 of the total cost of the service.<br><br>Depending on the type of services, a copayment, coinsurance, or deductible may apply. Cost sharing does not apply to preventive services.<br><br>Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).<br><br>See specialist visit for OB/Gyn office visits coverage. |
| | Childbirth/delivery professional services | After Deductible 10% Coinsurance | After Deductible 10% Coinsurance | After Deductible 40% Coinsurance | |
| | Childbirth/delivery Facility services | After Deductible 10% Coinsurance | After Deductible 10% Coinsurance $5,000 Copay/ admission for certain providers | After Deductible 40% Coinsurance | |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Tier 1 (You will pay the least) | Tier 2 (You may pay more) | Non-Preferred Provider (You will pay the most) | |
| If you need help recovering or have other special health needs | Home health care | After Deductible 10% Coinsurance | After Deductible 10% Coinsurance | After Deductible 40% Coinsurance | Pre-authorization is required. Failure to pre-authorize may result in no or reduced coverage. |
| | Rehabilitation services | After Deductible 10% Coinsurance | After Deductible 10% Coinsurance | After Deductible 40% Coinsurance | No daily or annual visits limitation apply. Services by primary care physician or specialist covered as noted on page 2.<br><br>Plan covers massage therapy provided by a licensed massage therapist at 20% coinsurance for Tiers 1 & 2 and 40% coinsurance for non-preferred provider. |
| | Habilitation services | After Deductible 10% Coinsurance | After Deductible 10% Coinsurance | After Deductible 40% Coinsurance | |
| | Skilled nursing care | After Deductible 10% Coinsurance | After Deductible 10% Coinsurance | After Deductible 40% Coinsurance | Limited to 180 days/benefit year. Pre-authorization required. If you don't get pre-authorization, benefits may be reduced by $500 of the total cost of the service. |
| If you need help recovering or have other special health needs | Durable medical equipment | After Deductible 0% Coinsurance | After Deductible 10% Coinsurance | After Deductible 40% Coinsurance | Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. Pre-authorization required. If you don't get pre-authorization, prior to the rental, purchase or certain repairs, benefits will be reduced by $100 of the total cost of the service.<br><br>Benefits for non-medically necessary foot orthotics are no charge, limited to one pair every five years for covered employees. |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Tier 1 (You will pay the least) | Tier 2 (You may pay more) | Non-Preferred Provider (You will pay the most) | |
| **If you need help recovering or have other special health needs** | Hospice services | After Deductible 10% Coinsurance | After Deductible 10% Coinsurance | After Deductible 40% Coinsurance | Pre-authorization is required. |
| **If your child needs dental or eye care** | Children's eye exam | Not Covered | Not Covered | Not Covered | See your Employer for benefit details. |
| | Children's glasses | Not Covered | Not Covered | Not Covered | See your Employer for benefit details. |
| | Children's dental check-up | Not Covered | Not Covered | Not Covered | See your Employer for benefit details. |

## 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.)

- Chiropractic Care
- Cosmetic Surgery
- Routine Dental Care (Adult)
- Routine Dental Care (Child)
- Long-Term Care
- Routine Eye Care (Adult)
- Routine Eye Care (Child)
- Routine Foot Care
- Weight Loss Programs

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

- Acupuncture, 20 visits/benefit year
- Massage Therapy
- Hearing Aids up to $2,500 maximum/three years
- Fertility Treatment up to $30,000/lifetime
- Non-emergency Care when traveling outside of the U.S.
- Nutritional Counseling
- Private Duty Nursing

**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: The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa. 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 on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 833-584-1828 or visit us at https:www.MyHealthToolkitCapital.com, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa.

**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 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: Para obtener asistencia en español, llame al número de atención al cliente que aparece en la primera página de esta notificación.

Tagalog: Upang makakuha ng tulong sa Tagalog, tawagan ang numero ng *customer service* na makikita sa unang pahina ng paunawang ito.

Chinese: 如需中文服务，请致电列于本通知首页的客户服务号码。

Navajo: T'áá Dinéjí shił hane'go shíká i'doolwoł nínízingo éí Nidaalnishígíí Áká Anídaalwo'ígíí, customer service, bich'į' hodíilnih. Bik'ehgo bich'į' hane'igíí éí díí naaltsoos neiyi'nilígíí akáa'gi siłtsoozígíí bikáá' íishjáąh.

———————————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*———————————

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

**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** | **$2,000** |
| **Specialist Copayment** | **$35** |
| **Hospital (facility) Coinsurance** | **10%** |
| **Other Coinsurance** | **10%** |

**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** |

**In this example, Peg would pay**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,000 |
| Copayments | $35 |
| Coinsurance | $900 |
| *What isn't covered* | |
| Limits or exclusions | $70 |
| **The total Peg would pay is** | **$3,005** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$2,000** |
| **Specialist Copayment** | **$35** |
| **Hospital (facility) Coinsurance** | **10%** |
| **Other Coinsurance** | **10%** |

**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** |

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,000 |
| Copayments | $140 |
| Coinsurance | $1,000 |
| *What isn't covered* | |
| Limits or exclusions | $200 |
| **The total Joe would pay is** | **$3,340** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$2,000** |
| **Specialist Copayment** | **$35** |
| **Hospital (facility) Coinsurance** | **10%** |
| **Other Coinsurance** | **10%** |

**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** |

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,000 |
| Copayments | $70 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $10 |
| **The total Mia would pay is** | **$2,280** |

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:**833-584-1828.**

## Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

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.

If you think we have not provided these services or have discriminated in any way, you can file a grievance by emailing contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD)

---

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 đở 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 تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات
الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 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 باره‌ی این برنامه‌ی 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 شماره‌ی 1-844-398-6233 تماس حاصل نمایید.
(Persian-Farsi)

Ni da doodago t'áá háída bíká'aná nílwo'ígíí díí Béeso Ách'ą́ąh naa'nilígi háá'ída yí na' ídíł kidgo, nihá'áhóót'i' nihí ká'a'doo wołgo kwii ha'át'íshíį́ bí na'ídołkidígi doo bik'é'azláagóó. Ata' halne'é ła' bich'į' ha desdzih nínízingo, kojį' béésh bee hólne' 1-844-516-6328. (Navajo)