

## Worthington Steel, Inc.: HRA Blue Plan



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, <https://eoc.anthem.com/eocdps/aso>. 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 (888) 971-7377 to request a copy.

| Important Questions                                                | Answers                                                                                                                                                                                                              | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall deductible?</b>                             | \$1,950/single or \$3,900/family for In-Network Providers.<br>\$1,950/single or \$3,900/family for Out-of-Network Providers.<br>An HRA is available to reimburse you for certain deductible and coinsurance amounts. | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <b>plan</b> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <b>plan</b> begins to pay.                                                                                                                                                                                                                                                                     |
| <b>Are there services covered before you meet your deductible?</b> | Yes. <u>Preventive Care</u> . For more information see below.                                                                                                                                                        | This <b>plan</b> 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 <b>plan</b> 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                  |
| <b>Are there other deductibles for specific services?</b>          | No.                                                                                                                                                                                                                  | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>What is the out-of-pocket limit for this plan?</b>              | \$3,800/single or \$7,600/family for In-Network Providers.<br>\$5,300/single or \$10,600/family for Out-of-Network Providers.                                                                                        | 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 plan, the overall family <u>out-of-pocket limit</u> must be met.                                                                                                                                                                                                                                                                                                                                                  |
| <b>What is not included in the out-of-pocket limit?</b>            | <u>Premiums</u> , <u>balance-billing</u> charges, and health care this <b>plan</b> doesn't cover.                                                                                                                    | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Will you pay less if you use a network provider?</b>            | Yes. BlueCard PPO. See <a href="http://www.anthem.com">www.anthem.com</a> or call (833) 824-1434 for a list of <u>network providers</u> . Costs may vary by site of service and how the <u>provider</u> bills.       | This <b>plan</b> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <b>plan's network</b> . 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</u> charge and what your <b>plan</b> 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.                                                                |
| <b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b> | 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                                                                                                                  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|-------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                     |                                                                   | In-Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                         |
| <b>If you visit a health care provider's office or clinic</b>                                                                                                                                       | Primary care visit to treat an injury or illness                  | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | -----none-----                                                                                                                                                          |
|                                                                                                                                                                                                     | <u>Specialist</u> visit                                           | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | -----none-----                                                                                                                                                          |
|                                                                                                                                                                                                     | <u>Preventive care</u> / <u>screening</u> / <u>immunization</u>   | No charge                                       | No charge                                          | You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. |
| <b>If you have a test</b>                                                                                                                                                                           | <u>Diagnostic test</u> (x-ray, blood work)                        | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | -----none-----                                                                                                                                                          |
|                                                                                                                                                                                                     | Imaging (CT/PET scans, MRIs)                                      | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | -----none-----                                                                                                                                                          |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.navitus.com">www.navitus.com</a> | Typically Generic (Tier 1)                                        | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | *See Prescription Drug section.                                                                                                                                         |
|                                                                                                                                                                                                     | Typically Preferred Brand & Non-Preferred Generic Drugs (Tier 2)  | 25% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             |                                                                                                                                                                         |
|                                                                                                                                                                                                     | Typically Non-Preferred Brand and Generic drugs (Tier 3)          | 30% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             |                                                                                                                                                                         |
|                                                                                                                                                                                                     | Typically Preferred <u>Specialty</u> (brand and generic) (Tier 4) | 30% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             |                                                                                                                                                                         |
| <b>If you have outpatient surgery</b>                                                                                                                                                               | Facility fee (e.g., ambulatory surgery center)                    | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | -----none-----                                                                                                                                                          |
|                                                                                                                                                                                                     | Physician/surgeon fees                                            | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | -----none-----                                                                                                                                                          |
| <b>If you need immediate medical attention</b>                                                                                                                                                      | <u>Emergency room care</u>                                        | 20% <u>coinsurance</u>                          | Covered as In- <u>Network</u>                      | -----none-----                                                                                                                                                          |
|                                                                                                                                                                                                     | <u>Emergency medical transportation</u>                           | 20% <u>coinsurance</u>                          | Covered as In- <u>Network</u>                      | -----none-----                                                                                                                                                          |

\* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/aso>.

| Common Medical Event                                                      | Services You May Need                     | What You Will Pay                                                                    |                                                                                      | Limitations, Exceptions, & Other Important Information                                           |
|---------------------------------------------------------------------------|-------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|
|                                                                           |                                           | In-Network Provider<br>(You will pay the least)                                      | Out-of-Network Provider<br>(You will pay the most)                                   |                                                                                                  |
|                                                                           | <u>Urgent care</u>                        | 20% <u>coinsurance</u>                                                               | 40% <u>coinsurance</u>                                                               | -----none-----                                                                                   |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)        | 20% <u>coinsurance</u>                                                               | 40% <u>coinsurance</u>                                                               | -----none-----                                                                                   |
|                                                                           | Physician/surgeon fees                    | 20% <u>coinsurance</u>                                                               | 40% <u>coinsurance</u>                                                               | -----none-----                                                                                   |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | Office Visit<br>20% <u>coinsurance</u><br>Other Outpatient<br>20% <u>coinsurance</u> | Office Visit<br>40% <u>coinsurance</u><br>Other Outpatient<br>40% <u>coinsurance</u> | Office Visit<br>-----none-----<br>Other Outpatient<br>-----none-----                             |
|                                                                           | Inpatient services                        | 20% <u>coinsurance</u>                                                               | 40% <u>coinsurance</u>                                                               | -----none-----                                                                                   |
| If you are pregnant                                                       | Office visits                             | 20% <u>coinsurance</u>                                                               | 40% <u>coinsurance</u>                                                               | Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
|                                                                           | Childbirth/delivery professional services | 20% <u>coinsurance</u>                                                               | 40% <u>coinsurance</u>                                                               |                                                                                                  |
|                                                                           | Childbirth/delivery facility services     | 20% <u>coinsurance</u>                                                               | 40% <u>coinsurance</u>                                                               |                                                                                                  |
| If you need help recovering or have other special health needs            | <u>Home health care</u>                   | 20% <u>coinsurance</u>                                                               | 40% <u>coinsurance</u>                                                               | -----none-----                                                                                   |
|                                                                           | <u>Rehabilitation services</u>            | 20% <u>coinsurance</u>                                                               | 40% <u>coinsurance</u>                                                               | *See Therapy Services section.                                                                   |
|                                                                           | <u>Habilitation services</u>              | 20% <u>coinsurance</u>                                                               | 40% <u>coinsurance</u>                                                               |                                                                                                  |
|                                                                           | <u>Skilled nursing care</u>               | 20% <u>coinsurance</u>                                                               | 40% <u>coinsurance</u>                                                               | 60 days/benefit period for skilled nursing services.                                             |
|                                                                           | <u>Durable medical equipment</u>          | 20% <u>coinsurance</u>                                                               | 40% <u>coinsurance</u>                                                               | *See <u>Durable Medical Equipment</u> section.                                                   |
|                                                                           | <u>Hospice services</u>                   | 0% <u>coinsurance</u>                                                                | 0% <u>coinsurance</u>                                                                | -----none-----                                                                                   |
| If your child needs dental or eye care                                    | Children's eye exam                       | Not covered                                                                          | Not covered                                                                          | -----none-----                                                                                   |
|                                                                           | Children's glasses                        | Not covered                                                                          | Not covered                                                                          |                                                                                                  |
|                                                                           | Children's dental check-up                | Not covered                                                                          | Not covered                                                                          | -----none-----                                                                                   |

### 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.)**

- |                              |                                                                  |                        |
|------------------------------|------------------------------------------------------------------|------------------------|
| • Children's dental check-up | • Cosmetic surgery                                               | • Dental care (Adult)  |
| • Eye exams for a child      | • Glasses for a child                                            | • Hearing Aids         |
| • Infertility treatment      | • Long-term care                                                 | • Private-duty nursing |
| • Routine eye care (Adult)   | • Routine foot care unless you have been diagnosed with diabetes | • Weight loss programs |

\* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/aso>.

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

- Acupuncture 20 visits/benefit period
- Most coverage provided outside the United States. See [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)
- Bariatric surgery
- Chiropractic care 20 visits/benefit period

**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: Ohio Department of Insurance, 50 W. Town Street, Third Floor - Suite 300, Columbus, Ohio 43215, (800) 686-1526, (614) 644-2673, Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or contact Anthem at the number on the back of your ID card. 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 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:

ATTN: Grievances and Appeals, P.O. Box 105568, Atlanta GA 30348-5568

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

**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.

*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> | \$1,950 |
| ■ <u>Specialist coinsurance</u>               | 20%     |
| ■ Hospital (facility) <u>coinsurance</u>      | 20%     |
| ■ Other <u>coinsurance</u>                    | 20%     |

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
Diagnostic tests (*ultrasounds and blood work*)  
Specialist visit (*anesthesia*)

|                    |          |
|--------------------|----------|
| Total Example Cost | \$12,750 |
|--------------------|----------|

In this example, Peg would pay:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$1,950        |
| <u>Copayments</u>                 | \$0            |
| <u>Coinsurance</u>                | \$2,160        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Peg would pay is</b> | <b>\$3,800</b> |

### 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> | \$1,950 |
| ■ <u>Specialist coinsurance</u>               | 20%     |
| ■ Hospital (facility) <u>coinsurance</u>      | 20%     |
| ■ Other <u>coinsurance</u>                    | 20%     |

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
Diagnostic tests (*blood work*)  
Prescription drugs  
Durable medical equipment (*glucose meter*)

|                    |         |
|--------------------|---------|
| Total Example Cost | \$5,650 |
|--------------------|---------|

In this example, Joe would pay:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$1,950        |
| <u>Copayments</u>                 | \$0            |
| <u>Coinsurance</u>                | \$740          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Joe would pay is</b> | <b>\$2,690</b> |

### Mia's Simple Fracture

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

|                                               |         |
|-----------------------------------------------|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$1,950 |
| ■ <u>Specialist coinsurance</u>               | 20%     |
| ■ Hospital (facility) <u>coinsurance</u>      | 20%     |
| ■ Other <u>coinsurance</u>                    | 20%     |

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

|                    |         |
|--------------------|---------|
| Total Example Cost | \$2,850 |
|--------------------|---------|

In this example, Mia would pay:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$1,950        |
| <u>Copayments</u>                 | \$0            |
| <u>Coinsurance</u>                | \$180          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,130</b> |

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

## Language Access Services:

(TTY/TDD: 711)

**Albanian (Shqip):** Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (888) 971-7377

**Amharic (አማርኛ):** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (888) 971-7377 ይደውሉ።

**Arabic (العربية):** إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (888) 971-7377.

**Armenian (հայերեն):** Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (888) 971-7377:

**Bassa (Bàsɔ̀ Wùdù):** M̈ dyi dyi-diè-djè b̈é b̈édjé b̈á céè-djè nià k̈e dyí ní, ɔ m̈ò ni dyí-b̈édjèin-djè b̈é m̈ k̈é gbo-kpá-kpá k̈e b̈ɔ̈ kp̈ɔ̈ djé m̈ bídjí-wùdùùn b̈ó pídyi. B̈é m̈ k̈é wuɖu-zìin-nyò d̈ò gbo wùdù k̈e, d̈á (888) 971-7377.

**Bengali (বাংলা):** যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (888) 971-7377 -তে কল করুন।

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖု (888) 971-7377 သို့ ခေါ်ဆိုပါ။

**Chinese (中文):** 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(888) 971-7377。

**Dinka (Dinka):** Na n̄ɔŋ thiëc nē ke de yā thorē, ke yin n̄ɔŋ loŋ bē yi kuony ku w̄er alēu bē ḡɛɛr yic yin ne thoŋ du ke cin w̄eu tāāuē ke piny. Te k̄or yin ba jam w̄enē ran ye thok geryic, ke yin c̄ol (888) 971-7377.

**Dutch (Nederlands):** Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (888) 971-7377.

**Farsi (فارسي):** در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (888) 971-7377 تماس بگیرید.

## Language Access Services:

**French (Français) :** Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (888) 971-7377.

**German (Deutsch):** Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (888) 971-7377.

**Greek (Ελληνικά)** Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (888) 971-7377.

**Gujarati (ગુજરાતી):** જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (888) 971-7377.

**Haitian Creole (Kreyòl Ayisyen):** Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (888) 971-7377.

**Hindi (हिंदी):** अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है।  
दुभाषिये से बात करने के लिए, कॉल करें (888) 971-7377 ।

**Hmong (White Hmong):** Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (888) 971-7377.

**Igbo (Igbo):** O bụrụ na ị nwere ajuju o bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ugwo o bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (888) 971-7377.

**Ilokano (Ilokano):** Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (888) 971-7377.

**Indonesian (Bahasa Indonesia):** Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (888) 971-7377.

**Italian (Italiano):** In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (888) 971-7377

**Japanese (日本語):** この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(888) 971-7377 にお電話ください。

## Language Access Services:

**Khmer (ខ្មែរ):** បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។  
ដើម្បីជ្រកជាមួយអ្នកបកប្រែ សូមហៅ(888) 971-7377 ។

**Kirundi (Kirundi):** Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (888) 971-7377.

**Korean (한국어):** 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(888) 971-7377 로 문의하십시오.

**Lao (ພາສາລາວ):** ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.  
ເພື່ອໂອ້ນລັກກັບລາມແປພາສາ, ໃຫ້ໂທຫາ (888) 971-7377.

**Navajo (Diné):** Díí naaltsoos biká'ígíí lahgo bina'idílkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee níł hodoonih t'áadoo báááh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih nínízingo kojí' hodiílnih (888) 971-7377.

**Nepali (नेपाली):** यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ।  
दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (888) 971-7377

**Oromo (Oromifaa):** Sanadi kanaa wajjin walqabaate gaffi kamiyyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (888) 971-7377 bilbilla.

**Pennsylvania Dutch (Deutsch):** Wann du Frooge iwwer selle Document hoscht, du hoscht die Recht um Hilfe un Information zu griege in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff (888) 971-7377 aa.

**Polish (polski):** W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer (888) 971-7377.

**Portuguese (Português):** Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para (888) 971-7377.

**Punjabi (ਪੰਜਾਬੀ):** ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਬਾਸੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ (888) 971-7377 ਤੇ ਕਾਲ ਕਰੋ।

## Language Access Services:

**Romanian (Română):** Dacă aveți întrebări referitoare la acest document, aveți dreptul să primiți ajutor și informații în limba dumneavoastră în mod gratuit. Pentru a vă adresa unui interpret, contactați telefonic (888) 971-7377.

**Russian (Русский):** если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (888) 971-7377.

**Samoan (Samoa):** Afai e iai ni ou fesili e uiga i lenei tusi, e iai lou 'aia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se totogi. Ina ia talanoa i se tagata faaliliu, vili (888) 971-7377.

**Serbian (Srpski):** Ukoliko imate bilo kakvih pitanja u vezi sa ovim dokumentom, imate pravo da dobijete pomoć i informacije na vašem jeziku bez ikakvih troškova. Za razgovor sa prevodiocem, pozovite (888) 971-7377.

**Spanish (Español):** Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (888) 971-7377.

**Tagalog (Tagalog):** Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (888) 971-7377.

**Thai (ไทย):** หากท่านมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร (888) 971-7377 เพื่อพูดคุยกับล่าม

**Ukrainian (Українська):** якщо у вас виникають запитання з приводу цього документа, ви маєте право безкоштовно отримати допомогу й інформацію вашою рідною мовою. Щоб отримати послуги перекладача, зателефонуйте за номером (888) 971-7377.

**Urdu (اردو):** اگر اس دستاویز کے بارے میں آپ کا کوئی سوال ہے، تو آپ کو مدد اور اپنی زبان میں مفت معلومات حاصل کرنے کا حق حاصل ہے۔ کسی مترجم سے بات کرنے کے لئے، (888) 971-7377 پر کال کریں۔

**Vietnamese (Tiếng Việt):** Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (888) 971-7377.

**(Yiddish) (אידיש):** אויב איר האט שאלות וועגן דעם דאקומענט, האט איר די רעכט צו באקומען דעם אינפארמאציע אין אייער שפראך אהן קיין פרייז. צו רעדן צו אן איבערזעצער, רופט (888) 971-7377.

**Yoruba (Yorùbá):** Tí o bá ní èyíkéyí ìbèrè nípa àkọsílẹ̀ yí, o ní ètọ́ láti gba ìrànwọ́ àti ìwífún ní èdè rẹ lẹ́fẹ́. Bá wa ògbùfọ̀ kan sọrọ̀, pe (888) 971-7377.

## Language Access Services:

### **It's important we treat you fairly**

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>.