



South Carolina

South Carolina Student Health Insurance Consortium : MUSC Mandatory



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 **1.855.823.0319**. 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 **1.855.823.0319** to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| What is the overall <u>deductible</u>? | In-Network \$500 person/ \$1,000 family. Out-of-Network \$3,000 person/ \$6,000 family. | Generally, you must pay all 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> . |
| Are there services covered before you meet your <u>deductible</u>? | Yes. <u>Preventive care</u> services, some <u>prescription drugs</u> , Routine Vision, and Routine Dental services 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 <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 <u>deductibles</u> for specific services? | Yes. Prescription Drug: \$100 <u>deductible</u> at In-Network and Out-of-Network pharmacies only. The Prescription Drug <u>deductible</u> does not apply to prescriptions filled at the at onsite pharmacies. | You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services. |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u>? | In-Network \$9,200 person/ \$15,000 family. Out-of-Network \$15,000 person/ \$30,000 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 <u>out-of-pocket limit</u>? | <u>Premiums</u> , <u>balance-billing</u> charges, chiropractic services, <u>out-of-network copayments</u> , 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 <u>network provider</u>? | Yes. See www.SouthCarolinaBlues.com or call 1-800-810-BLUE (2583) for a list of <u>network providers</u> . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</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 <u>referral</u> to see a <u>specialist</u>? | 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 |
|---|--|--|---|---|
| | | <u>In-Network Provider</u> (You will pay the least) | <u>Out-of-Network Provider</u> (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$25 <u>Copay</u> / visit then 20% <u>Coinsurance</u> | \$40 <u>Copay</u> / visit then 30% <u>Coinsurance</u> | Services administered at the Student Health Center will be covered at 100%. Some services administered at the Student Health Center will require a \$20 <u>copay</u> /visit. |
| | <u>Specialist</u> visit | \$25 <u>Copay</u> / visit then 20% <u>Coinsurance</u> | \$40 <u>Copay</u> / visit then 30% <u>Coinsurance</u> | Services administered at the Student Health Center will be covered at 100%. Some services administered at the Student Health Center will require a \$20 <u>copay</u> /visit. |
| | <u>Preventive care/screening/immunization</u> | No Charge | Not Covered | See www.healthcare.gov for <u>preventive care</u> guidelines. There may be additional benefits available. See your University for details. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | 20% <u>Coinsurance</u> | 30% <u>Coinsurance</u> | Services administered at the Student Health Center will be covered at 100%. Some services administered at the Student Health Center will require a \$20 <u>copay</u> /visit. |
| | Imaging (CT/PET scans, MRIs) | \$150 <u>Copay</u> / test then 20% <u>Coinsurance</u> | \$300 <u>Copay</u> / test then 30% <u>Coinsurance</u> | <u>Pre-authorization</u> is required. Penalty for not obtaining <u>pre-authorization</u> is denial of all charges. |
| If you need drugs to treat your illness or condition | Generic drugs (Retail) | \$20 <u>Copay</u> / prescription | \$20 <u>Copay</u> / prescription | 90 day supply. <u>Copay</u> applies to each 31 day supply. Generic prescriptions filled at an onsite pharmacy are covered at a \$10 <u>copay</u> /prescription; RX <u>deductible</u> does not apply at the onsite pharmacy. |
| | Generic drugs (Mail Order) | Not Covered | Not Covered | None |
| | Preferred brand drugs (Retail) | \$40 <u>Copay</u> / prescription | \$40 <u>Copay</u> / prescription | 31 day supply. Preferred Brand prescriptions filled at an onsite pharmacy are covered at a \$20 <u>copay</u> /prescription; RX <u>deductible</u> does not apply at the onsite pharmacy. |
| | Preferred brand drugs (Mail Order) | Not Covered | Not Covered | None |
| More information about prescription drug coverage is available at www.SouthCarolinaBlues.com | | | | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|---|---|--|
| | | <u>In-Network Provider</u> (You will pay the least) | <u>Out-of-Network Provider</u> (You will pay the most) | |
| | Non-preferred brand drugs (Retail) | \$100 <u>Copay</u> / prescription | \$100 <u>Copay</u> / prescription | 31 day supply. Non-Preferred Brand prescriptions filled at an onsite pharmacy are covered at a \$20 <u>copay</u> /prescription; RX <u>deductible</u> does not apply at the onsite pharmacy. |
| | Non-preferred brand drugs (Mail Order) | Not Covered | Not Covered | None |
| | <u>Specialty drugs</u> | \$100 <u>Copay</u> / prescription; <u>deductible</u> does not apply | Not Covered | 31 day supply. Available at an approved Specialty Pharmacy or onsite pharmacy only. <u>Specialty Drugs</u> are covered at a \$20 <u>copay</u> /prescription at an onsite pharmacy. RX <u>deductible</u> does not apply at the onsite pharmacy. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% <u>Coinsurance</u> | 30% <u>Coinsurance</u> | <u>Pre-authorization</u> is required for some outpatient surgeries. Penalty for not obtaining <u>pre-authorization</u> is 50% of the allowable charge. |
| | Physician/surgeon fees | 20% <u>Coinsurance</u> | 30% <u>Coinsurance</u> | None |
| If you need immediate medical attention | <u>Emergency room care</u> | \$200 <u>Copay</u> / visit then 20% <u>Coinsurance</u> | \$200 <u>Copay</u> / visit then 20% <u>Coinsurance</u> | <u>Copayment</u> will be waived if admitted. |
| | <u>Emergency medical transportation</u> | 20% <u>Coinsurance</u> | 20% <u>Coinsurance</u> | None |
| | <u>Urgent care</u> | \$75 <u>Copay</u> / visit then 20% <u>Coinsurance</u> | \$75 <u>Copay</u> / visit then 30% <u>Coinsurance</u> | Doctor's Care is covered at a \$25 <u>Copay</u> /visit then 20% <u>Coinsurance</u> . |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% <u>Coinsurance</u> | 30% <u>Coinsurance</u> | <u>Pre-authorization</u> is required. Penalty for not obtaining <u>pre-authorization</u> is denial of room and board. |
| | Physician/surgeon fees | 20% <u>Coinsurance</u> | 30% <u>Coinsurance</u> | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|--|--|---|--|
| | | <u>In-Network Provider</u> (You will pay the least) | <u>Out-of-Network Provider</u> (You will pay the most) | |
| If you need mental health, behavioral health, or substance abuse services | Mental/behavioral health outpatient services | 20% <u>Coinsurance</u> | 30% <u>Coinsurance</u> | Pre-authorization is required. Penalty for not obtaining pre-authorization is 50% of the allowable charge. Office visits are covered at a \$40 <u>copay</u> /visit In-Network; <u>deductible</u> does not apply. Office visits do not require pre-authorization. Out-of-Network office visits are covered at a \$40 <u>copay</u> then 30% <u>Coinsurance</u> /visit. Psychiatric office visits are covered at a \$20 <u>copay</u> /visit at the Student Health Center; <u>deductible</u> does not apply. |
| | Substance use disorder outpatient services | 20% <u>Coinsurance</u> | 30% <u>Coinsurance</u> | |
| | Mental/behavioral health inpatient services | 20% <u>Coinsurance</u> | 30% <u>Coinsurance</u> | Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of room and board. |
| | Substance use disorder inpatient services | 20% <u>Coinsurance</u> | 30% <u>Coinsurance</u> | |
| If you are pregnant | Office visits | \$25 <u>Copay</u> / visit then 20% <u>Coinsurance</u> | \$40 <u>Copay</u> / visit then 30% <u>Coinsurance</u> | Pre-authorization for facility services is required. Penalty for not obtaining pre-authorization is denial of room and board. Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. <u>Cost sharing</u> does not apply for <u>preventive services</u> . |
| | Childbirth/delivery professional services | 20% <u>Coinsurance</u> | 30% <u>Coinsurance</u> | |
| | Childbirth/delivery facility services | 20% <u>Coinsurance</u> | 30% <u>Coinsurance</u> | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 20% <u>Coinsurance</u> | 30% <u>Coinsurance</u> | 60 visits/benefit year. Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of all charges. |
| | <u>Rehabilitation services</u> | 20% <u>Coinsurance</u> | 30% <u>Coinsurance</u> | 30 combined visits/benefit year for Occupational Therapy & Physical Therapy. 20 visits/benefit year for Speech Therapy. Services administered at the Student Health Center will be covered at 100%; <u>deductible</u> does not apply. Physical Therapy evaluations are covered at a \$20 <u>copay</u> /benefit year. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|----------------------------------|--|---|---|
| | | <u>In-Network Provider</u> (You will pay the least) | <u>Out-of-Network Provider</u> (You will pay the most) | |
| | <u>Habilitation services</u> | 20% <u>Coinsurance</u> | 30% <u>Coinsurance</u> | 30 combined visits/benefit year for Occupational Therapy & Physical Therapy. 20 visits/benefit year for Speech Therapy. Services administered at the Student Health Center will be covered at 100%; <u>deductible</u> does not apply. Physical Therapy evaluations are covered at a \$20 <u>copay</u> /benefit year. |
| | <u>Skilled nursing care</u> | 20% <u>Coinsurance</u> | 30% <u>Coinsurance</u> | 60 days/benefit year. <u>Pre-authorization</u> is required. Penalty for not obtaining <u>pre-authorization</u> is denial of room and board. |
| | <u>Durable medical equipment</u> | \$25 <u>Copay</u> then 20% <u>Coinsurance</u> | \$40 <u>Copay</u> then 30% <u>Coinsurance</u> | Purchase or rentals of \$500 or more require <u>pre-authorization</u> . Penalty for not obtaining <u>pre-authorization</u> is denial of all charges. <u>Durable Medical Equipment</u> obtained at the Student Health Center is covered at a \$20 <u>copay</u> /device. |
| | <u>Hospice services</u> | 20% <u>Coinsurance</u> | 30% <u>Coinsurance</u> | 6 months/episode. <u>Pre-authorization</u> is required. Penalty for not obtaining <u>pre-authorization</u> is denial of all charges. |
| If your child needs dental or eye care | Children's eye exam | No Charge | No Charge | Limited to one visit/member under the age of 18/benefit year. Routine eye exams for members over age 18 are covered at a \$20 <u>copay</u> /visit. Limited to one visit/member/benefit year. OON services are covered up to \$30. |
| | Children's glasses | No Charge | No Charge | Limited to one pair of prescribed lenses and frames or a 12 month supply of contact lenses/member under age 18/benefit year. For members over age 18, In-Network frames are covered at a \$0 <u>copay</u> and are limited to a \$150 allowance. Standard lenses are covered at a \$20 <u>copay</u> (single, bifocal, and trifocal). Out-of-Network lenses are covered up to \$25 (single), \$40 (bifocal), and \$55 (trifocal). |
| | Children's dental check-up | No Charge | No Charge | Limited to two routine oral exams/member/benefit year. |

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.)

- | | | |
|---------------------|-------------------------|------------------------|
| • Acupuncture | • Hearing Aids | • Private-Duty Nursing |
| • Bariatric Surgery | • Infertility Treatment | • Routine Foot Care |
| • Cosmetic Surgery | • Long-Term Care | • Weight Loss Programs |

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

- | | | |
|---|--|----------------------------|
| • Chiropractic Care (excludes office visit/unattended electrical stimulation) | • Dental Care (Child) | • Routine Eye Care (Adult) |
| • Dental Care (Adult) | • Non-emergency care when traveling outside the U.S. | • Routine Eye Care (Child) |

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 Health and Human Services Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov, the South Carolina State Department of Insurance at 1-800-768-3467 or visit www.doi.sc.gov. 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: 1.855.823.0319 or visit us at www.SouthCarolinaBlues.com, the South Carolina State Department of Insurance at 1-800-768-3467 or visit www.doi.sc.gov

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet 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 Dinéji shíł hane'go shiká i'doolwoł nínizingo éi Nidaalnishigíí Áká Anídaalwo'ígíí, customer service, bich'í' hodiilnih. Bik'ehgo bich'í' hane'ígíí éi díi naaltsoos neiyi'níligíí akáa'gí sítsoozígíí bikáá' íishjááh.

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 <u>plan's</u> overall <u>deductible</u> | \$500 |
| ■ <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 | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| <u>Deductibles*</u> | \$500 |
| <u>Copayments</u> | \$10 |
| <u>Coinsurance</u> | \$2,400 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$2,970 |

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> | \$500 |
| ■ <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 | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| <u>Deductibles*</u> | \$500 |
| <u>Copayments</u> | \$1,100 |
| <u>Coinsurance</u> | \$200 |
| What isn't covered | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$1,820 |

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

| | |
|---|-------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$500 |
| ■ <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 | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| <u>Deductibles*</u> | \$500 |
| <u>Copayments</u> | \$10 |
| <u>Coinsurance</u> | \$500 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,010 |

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: **1.855.823.0319**.

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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

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 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 tinutulongan, 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 تساعد 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 nílwo'ígíí díí Béeso Ách'ááh naa'níligi 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 desdzhíh nínízingo, kojí' béesh bee hólne' 1-844-516-6328. (Navajo)
