The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact the claims administrator at 1-800-421-1362 or visit One.Walmart.com/Benefits. 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 https://www.healthcare.gov/sbc-glossary or call 1-800-421-1362 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters</th>
</tr>
</thead>
</table>
| What is the overall deductible? | In-Network: $1,750 individual/ $3,500 family
Out-of-Network: Services are not covered
Charges for balance-billing, healthcare this plan does not cover, out-of-network care, services at an out-of-network Walmart Care Clinic or Walmart Health, medical copayments, pharmacy copayment/coinsurance, and amounts the plan pays at 100% do not count toward the deductible. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay. |
| Are there services covered before you meet your deductible? | Yes. Deductible is waived for: Doctor on Demand, certain services that are included in the Centers of Excellence programs (except bariatric surgery), eligible pharmacy charges, certain preventive care services, and in-network office visits. | 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 certain preventive services 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? | In-Network: $6,850 individual/ $13,700 family
Out-of-Network: Services are not covered | The 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, penalties for failure to obtain preauthorization for services, charges for health care this plan doesn't cover, charges for out-of-network care, charges for services at an out-of-network Walmart Care Clinic or Walmart Health, and amounts the plan pays at 100%. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |

* For more information about limitations and exceptions, see the Summary Plan Description ( SPD) at One.Walmart.com/Benefits.
### Important Questions

<table>
<thead>
<tr>
<th><strong>Answers</strong></th>
<th><strong>Why This Matters:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Will you pay less if you use a network provider?</strong></td>
<td>Yes. See <a href="https://One.Walmart.com/Benefits">One.Walmart.com/Benefits</a> or call 1-800-421-1362 for a list of network providers. This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td><strong>Do you need a referral to see a specialist?</strong></td>
<td>No. You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>

---

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

---

### Limitations, Exceptions, & Other Important Information

<table>
<thead>
<tr>
<th><strong>Common Medical Event</strong></th>
<th><strong>Services You May Need</strong></th>
<th><strong>What You Will Pay</strong></th>
<th><strong>In-Network Provider</strong></th>
<th><strong>Out-of-Network Provider</strong></th>
<th><strong>Limitations, Exceptions, &amp; Other Important Information</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td><strong>In-Network Provider</strong> (You will pay the least)</td>
<td>$35 copay/visit; deductible doesn't apply</td>
<td><strong>Out-of-Network Provider</strong> (You will pay the most)</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$75 copay/visit; deductible doesn't apply</td>
<td>Not covered</td>
<td></td>
<td>Preauthorization may be required. “See the “Preauthorization” section in the Summary Plan Description.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>Not covered</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>25% coinsurance</td>
<td>Not covered</td>
<td></td>
<td>There is no charge for in-office services or in-network preventive services. “See the “Preventive care program” section in the SPD for covered preventive services.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>25% coinsurance</td>
<td>Not covered</td>
<td></td>
<td>Preauthorization may be required. “See the “Preauthorization” section in the Summary Plan Description.</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic drugs</td>
<td>$4 copayment (1-30 days); $8 copayment (31-60 days); $12 copayment (61-90 days)</td>
<td>Not covered</td>
<td></td>
<td>You must use a Walmart or Sam’s Club pharmacy (including through mail-order). “See “The Pharmacy Benefit” section in the SPD for exceptions. Supplies of preferred brand drugs of more than 30 days must be purchased by mail-order.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>25% coinsurance (30 days)</td>
<td>Not covered</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the Summary Plan Description (SPD) at [One.Walmart.com/Benefits](https://One.Walmart.com/Benefits).
<table>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><strong>In-Network Provider</strong> (You will pay the least) <strong>Out-of-Network Provider</strong> (You will pay the most)</td>
<td></td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at <a href="http://www.OptumRx.com/Walmart">www.OptumRx.com/Walmart</a></td>
<td>Non-preferred brand drugs</td>
<td>Not covered                                                                                 Not covered</td>
<td>Non-Preferred brand drugs are not covered.</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>20% coinsurance (30 days)                                                                                Not covered</td>
<td>Preauthorization may be required. *See the “Preauthorization” section in the Summary Plan Description. Specialty drugs are only available at a Walmart Specialty or OptumRx Specialty pharmacy. Prescriptions for specialty drugs are not covered when purchased at a non-network pharmacy.</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>25% coinsurance                                                                                       Not covered</td>
<td>Preauthorization may be required. *See the “Preauthorization” section in the Summary Plan Description.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>25% coinsurance                                                                                       Not covered</td>
<td>Preauthorization may be required. *See the “Preauthorization” section in the Summary Plan Description.</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$300 copay/visit, plus remaining annual deductible; coinsurance does not apply for emergency services.</td>
<td>$300 copay/visit, plus remaining annual deductible; coinsurance does not apply for emergency services; 50% coinsurance for non-emergency services</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>25% coinsurance                                                                                      25% coinsurance</td>
<td>Coverage is limited to the nearest hospital or treatment facility capable of providing care, and only if such transportation is medically necessary as compared to other transportation methods of lower cost and safety. Non-emergency transport not covered, except if pre-authorized.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>Office visits: $75 copayment/visit, deductible doesn’t apply;                                          25% coinsurance for emergency services; Not covered for non-emergency services</td>
<td>Care that does not meet the definition of “emergency services” is not covered for out-of-network services.</td>
</tr>
<tr>
<td></td>
<td>Facility fee (e.g., hospital room)</td>
<td>25% coinsurance                                                                                       Not covered</td>
<td>Preauthorization may be required. *See the “Preauthorization” section in the Summary Plan Description.</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the Summary Plan Description (SPD) at One.Walmart.com/Benefits.
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<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Physician/surgeon fees</td>
<td>25% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office Visit: $35 copay/visit; deductible doesn't apply; All other services: 25% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>25% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>Preventive care: No charge; All other services: $35 copay/visit; deductible doesn't apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>25% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>25% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>25% coinsurance</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

For heart surgery, dialysis/ESRD medical record review, spine, hip or knee replacement evaluation or surgery; breast, lung, blood, prostate, and colorectal cancer review; and organ and tissue transplants, coverage may be 100%, deductible waived, through the Centers of Excellence (COE) Program. When not performed through the COE Program, these services (other than heart surgery, dialysis/ESRD medical record review, and cancer medical record review) as well as weight loss surgery generally are not covered, even if performed by a network provider. *See the “Centers of Excellence” section in the Summary Plan Description.

Preauthorization may be required. *See the “Preauthorization” section in the Summary Plan Description.

Preauthorization may be required for stays exceeding standard length of stay for maternity. Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) 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.

Home health care is limited to 100 visits per calendar year. Preauthorization may be required. *See the “Preauthorization” section in the SPD. Other limitations may apply. *See the “When limited benefits apply to the Associates’ Medical Plan” section in the Summary Plan Description.

* For more information about limitations and exceptions, see the Summary Plan Description (SPD) at One.Walmart.com/Benefits.
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<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
</tbody>
</table>
| Rehabilitation services | 25% coinsurance | Not covered | Rehabilitation services are limited as follows:  
- Physical therapy limited to 20 visits/year.  
- Occupational therapy limited to 20 visits/year.  
- Speech therapy limited to 60 visits/year.  
- Certain other inpatient rehabilitation services are limited to 120 days per condition.  
See the “When Limited Benefits Apply to the Associates’ Medical Plan” section of the SPD. Preauthorization may be required. |
| Habilitation services | 25% coinsurance | Not covered | Habilitation services are limited to Applied Behavior Analysis therapy. Preauthorization may be required. *See the “Preauthorization” section in the SPD. |
| Skilled nursing care | 25% coinsurance | Not covered | Skilled nursing facilities are limited to 60 days per /disability period.  
*See the “When Limited Benefits Apply to the Associates’ Medical Plan” section in the SPD. Preauthorization may be required. |
| Durable medical equipment | 25% coinsurance | Not covered | Preauthorization may be required. *See the “Preauthorization” section in the SPD. Orthopedic shoes when prescribed by a physician are limited to one pair per calendar year. |
| Hospice services | 25% coinsurance | Not covered | Preauthorization may be required. *See the “Preauthorization” section in the SPD. Hospice services are limited to 365 days per illness. |

If your child needs dental or eye care

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
</tr>
<tr>
<td>Chiropractic care</td>
</tr>
<tr>
<td>Dental care</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the Summary Plan Description (SPD) at One.Walmart.com/Benefits.
Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)

- Bariatric surgery (gastric bypass and gastric sleeve surgery only)
- Cosmetic Surgery (limited to conditions that are considered reconstructive)
- Infertility treatment (limited to the diagnosis & treatment of underlying medical condition.
- Long-term care – Up to 60 days/disability period
- Non-Emergency Care when traveling Outside the U.S. (as provided by international business medical insurance policy)
- Private-duty nursing (limited to 100 visits per calendar, billed through a home health agency, and must be provided by a licensed or registered nurse)
- Routine eye care (limited to services and limitations that are identified under the “Preventive Care” section of the SPD)
- Routine foot care (nonsurgical foot care limited to 3 visits per calendar year)

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 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: Walmart People Services, Attn: Internal Appeals, 508 SW 8th Street, Bentonville, AR 72716-3500. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa or contact Aetna directly by calling the toll free number on your Medical ID Card or by calling our general toll free number at 1-800-421-1362. Additionally, a consumer assistance program can help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.

Does this plan provide Minimum Essential Coverage? Yes.
If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.
If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-421-1362.
Chinese (中文): 请拨打这个号码 1-800-421-1362.
Navajo (Dine): Dinek’ehgo shika a’ohwl ninisingo, kwijigo holne’ 1-800-421-1362.

------------To see examples of how this plan might cover costs for a sample medical situation, see the next section.-------------

* For more information about limitations and exceptions, see the Summary Plan Description (SPD) at One.Walmart.com/Benefits.
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: $1,750
- Specialist copayment: $75
- Hospital (facility) coinsurance: 25%
- Other coinsurance: 25%

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: $12,800
In this example, Peg would pay:
Cost Sharing
Deductibles: $1,750
Copayments: $0
Coinsurance: $2,700
What isn't covered
Limits or exclusions: $60
The total Peg would pay is: $4,510

Managing Joe’s type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)
- The plan's overall deductible: $1,750
- Specialist copayment: $75
- Hospital (facility) coinsurance: 25%
- Other coinsurance: 25%

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: $7,400
In this example, Joe would pay:
Cost Sharing
Deductibles: $1,750
Copayments: $400
Coinsurance: $1,300
What isn't covered
Limits or exclusions: $60
The total Joe would pay is: $3,510

Mia’s Simple Fracture
(in-network emergency room visit and follow up care)
- The plan's overall deductible: $1,750
- Specialist copayment: $75
- Hospital (facility) coinsurance: 25%
- Other coinsurance: 25%

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: $1,900
In this example, Mia would pay:
Cost Sharing
Deductibles: $1,600
Copayments: $300
Coinsurance: $0
What isn't covered
Limits or exclusions: $60
The total Mia would pay is: $1,900

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

* For more information about limitations and exceptions, see the Summary Plan Description ( SPD) at One.Walmart.com/Benefits.
**Assistive Technology**
Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-421-1362.

**Smartphone or Tablet**
To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

**Non-Discrimination**
Banner | Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Banner | Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512

1-800-648-7817, TTY: 711

Fax: 859-425-3379

Email: CRCordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Health benefits and health insurance plans are offered and/or underwritten by Banner Health and Aetna Health Plan Inc. and Banner Health and Aetna Health Insurance Company (Banner | Aetna). Banner | Aetna are affiliates of Banner Health and of Aetna Life Insurance Company and its affiliates (Aetna). Aetna provides certain management services to Banner |Aetna.
TTY: 711
Language Assistance:

For language assistance in your language call 1-800-421-1362 at no cost.

<table>
<thead>
<tr>
<th>Language</th>
<th>Assistance in your language call 1-800-421-1362 at no cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albanian</td>
<td>Për asistencë në gjuhën shqipe telefononi falas në 1-800-421-1362.</td>
</tr>
<tr>
<td>Amharic</td>
<td>እንግር አማርኛ መን ያለው ያለው እንግር አማርኛ 1-800-421-1362 መን ያለው ያለው.</td>
</tr>
<tr>
<td>Arabic</td>
<td>للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-421-1362.</td>
</tr>
<tr>
<td>Armenian</td>
<td>Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-800-421-1362 առանց գնով.</td>
</tr>
<tr>
<td>Bahasa Indonesia</td>
<td>Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-421-1362 tanpa dikenakan biaya.</td>
</tr>
<tr>
<td>Bantu-Kirundi</td>
<td>Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-800-421-1362 ku busa.</td>
</tr>
<tr>
<td>Bengali-Bangala</td>
<td>বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-800-421-1362-তে কল করুন।</td>
</tr>
<tr>
<td>Bisayan-Visayan</td>
<td>Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-421-1362 nga walay bayad.</td>
</tr>
<tr>
<td>Burmese</td>
<td>1-800-421-1362.</td>
</tr>
<tr>
<td>Catalan</td>
<td>Per rebre assistència en (català), truqui al número gratuït 1-800-421-1362.</td>
</tr>
<tr>
<td>Chamorro</td>
<td>Para ayuda gi fino’ (Chamoru), ågang 1-800-421-1362 sin gástu.</td>
</tr>
<tr>
<td>Cherokee</td>
<td>1-800-421-1362.</td>
</tr>
<tr>
<td>Chinese</td>
<td>欲取得繁體中文語言協助，請撥打1-800-421-1362，無需付費。</td>
</tr>
<tr>
<td>Choctaw</td>
<td>(Chahta) anumpa ya apela a chi l paya hinla 1-800-421-1362.</td>
</tr>
<tr>
<td>Cushite</td>
<td>Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofs baabilaa 1-800-421-1362 irratti bilisaan baabilaa.</td>
</tr>
<tr>
<td>Dutch</td>
<td>Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-421-1362.</td>
</tr>
<tr>
<td>French</td>
<td>Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-421-1362 gratis.</td>
</tr>
<tr>
<td>Greek</td>
<td>Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-421-1362 χωρίς χρέωση.</td>
</tr>
</tbody>
</table>
ગુજરાતીમાં લાખામાં સહાય માટે કોઈપણ પર અર્થ 1-800-421-1362 પર કોલ કરો.
No ke kōkua ma ka 'ōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-800-421-1362. Kāki 'ole ia kēia kōkua nei.

Hindi - हिंदी में भाषा सहायता के लिए, 1-800-421-1362 पर मुफ्त कॉल करें।

Hmong - Maka enyemaka aṣusṣu na Igbo kpọ 1-800-421-1362 na akwughị ụgwọ ọ bụla

Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-421-1362 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, puo' chiamare gratuitamente 1-800-421-1362.

Japanese - 日本語で援助をご希望の方は、1-800-421-1362まで無料でお電話ください。

Karen - Be’m kè gbo-kpà-kpà dyé pìdyi dë Basso-wuɖùn wée, ḋá 1-800-421-1362

Kurdish - برای راهنمایی به زبان فارسی با شماره 1-800-421-1362 تماس بگیرید. انگلیسی

Laotian - Pohnpeyan - Ohng palien sawas en soum kawewé ni omw loka Ponape koahl 1-800-421-1362 ni sohté isais.

Marathi - Ibo - Makaenyemaka asụsụ na Igbo kpọ 1-800-421-1362 na aputa ụche ụgbọ.

Marshallese - Marshallese - Ñan bōk jipaŋ ilo Kajin Majol, kallok 1-800-421-1362 ilo ejjelok wōnān.

Mon-Khmer, Cambodian - Navajo - T'áá shi shizaad k'ehji bee shiká a’doowol ninízingo Diné k'ehji koji' t'áá jiik’e hólne’ 1-800-421-1362

Nepali - Nepali - (नेपाली) मा लिएँ: शुल्क भाषा सहायता पाउनका लागि 1-800-421-1362 मा फोन गर्नुहोस्।

Nilotic-Dinka - Panjabi - Tën kuocn y thok e Thuoŋjāŋ col 1-800-421-1362 kecín ayôc.


Persian - Persia - برای راهنمایی به زبان فارسی با شماره 1-800-421-1362 تماس بگیرید.

Polish - Aby uzyskać pomoc w języku polskim, zadźwoń bezpłatnie pod numer 1-800-421-1362.
Para obter assistência linguística em português ligue para o 1-800-421-1362 gratuitamente.

Pentru asistență lingvistică în româneste telefonați la numărul gratuit 1-800-421-1362.

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-421-1362.

Mo fesoasoani tau gagana I le Gagana Samoa vala’au le 1-800-421-1362 e aunoa ma se totogi.

Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-421-1362.

Para obtener asistencia lingüística en español, llame sin cargo al 1-800-421-1362.

Pentru asistență lingvistică în românesc se telefonați la numărul gratuit 1-800-421-1362.

Para obtenir ayuda lingüística gratuita al 1-800-421-1362.

Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero d oo 1-800-421-1362. Njodi woo fawaaki on.

Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-421-1362 bila malipo.

Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-421-1362 nang walang bayad.

Lawa sahulugan sa wika Thai, papallo yong 1-800-421-1362 gugn ak bawal la pan-Thai.

Kapau ‘oku fiema’u hā tokoni ‘i he lea faka-Tonga telefoni 1-800-421-1362 ‘o ‘ikai hā ʻotōngi.

Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékékéé 1-800-421-1362 nge esapw kamé ngonuk.

(Dil) çağrısı dil yardımı için. Hiçbir ücret ödemeden 1-800-421-1362.

 Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-421-1362.

ايريك كامه رمب 1-800-421-1362. سنكل بكينت و اع من حل ري م و در

Để được hỗ trợ ngôn ngữ (ngôn ngữ), hãy gọi miễn phí đến số 1-800-421-1362.

Fún iránlọwọ nípa èdè (Yorùbá) pe 1-800-421-1362 lái san ówó kankan rará.
Valued Plan Participant

THE ASSOCIATES’ HEALTH AND WELFARE PLAN (AHWP) RESPECTS THE DIGNITY OF EACH INDIVIDUAL WHO PARTICIPATES IN THE PLAN.

The AHWP does not discriminate on the basis of race, color, national origin, sex, age, or disability and strictly prohibits retaliation against any person making a complaint of discrimination. Additionally, we gladly provide our participants with language assistance, auxiliary aids and services at no cost. We value you as our participant and your satisfaction is important to us.

If you need such assistance or have concerns with your Plan services, please call the number on the back of your plan ID card. If you have any questions or concerns, please use one of the methods below so that we can better serve you.

For assistance, call the number on the back of your plan ID card.

To learn about or use our grievance process, contact People Services at 800-421-1362.

To file a complaint of discrimination, contact the U.S. Department of Health and Human Services, Office of Civil Rights:
- Phone: 800-368-1019 or 800-537-7697 (TDD)
- Website: https://ocrportal.hhs.gov/ocr/cp/wizard_cp.jsf
- Email: OCRCompliant@hhs.gov

Interpreter Services are available at no cost. 800-421-1362

Português (Brasil)
Serviços de interprete estão disponíveis grátis. 1-800-421-1362.

Polski
Usługi tłumacza dostępne są bez żadnych kosztów. 1-800-421-1362.