### Important Questions | Answers | Why This Matters:
---|---|---
**What is the overall deductible?** | In-Network: $1,750 individual/ $3,500 family<br>Out-of-Network: Services are not covered<br><br>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/](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<br>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](https://One.Walmart.com/Benefits).*
<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="One.Walmart.com/Benefits">One.Walmart.com/Benefits</a> or call 1-800-421-1362 for a list of in-network providers.</td>
<td>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>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>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.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</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> <em>(You will pay the least)</em>: $35 copay/visit; deductible doesn't apply <strong>Out-of-Network Provider</strong> <em>(You will pay the most)</em>: Not covered</td>
<td>Special rules, including lower copayments, may apply to services received from an in-network Walmart Care Clinic or Walmart Health or via video visit. *See the “Walmart Care Clinic and Walmart Health” section of the SPD. Video visits have a $4 copayment and are covered only when provided through the Doctor on Demand service.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td><strong>In-Network Provider</strong> <em>(You will pay the least)</em>: $75 copay/visit; deductible doesn't apply <strong>Out-of-Network Provider</strong> <em>(You will pay the most)</em>: Not covered</td>
<td><em>Preauthorization</em> may be required. *See the “Preauthorization” section in the Summary Plan Description.</td>
</tr>
<tr>
<td></td>
<td>Preventive care /screening /immunization</td>
<td><strong>In-Network Provider</strong> <em>(You will pay the least)</em>: No charge <strong>Out-of-Network Provider</strong> <em>(You will pay the most)</em>: Not covered</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><strong>In-Network Provider</strong> <em>(You will pay the least)</em>: 25% coinsurance <strong>Out-of-Network Provider</strong> <em>(You will pay the most)</em>: Not covered</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><strong>In-Network Provider</strong> <em>(You will pay the least)</em>: 25% coinsurance <strong>Out-of-Network Provider</strong> <em>(You will pay the most)</em>: Not covered</td>
<td><em>Preauthorization</em> 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><strong>In-Network Provider</strong> <em>(You will pay the least)</em>: $4 copayment (1-30 days); $8 copayment (31-60 days); $12 copayment (61-90 days) <strong>Out-of-Network Provider</strong> <em>(You will pay the most)</em>: Not covered</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><strong>In-Network Provider</strong> <em>(You will pay the least)</em>: 25% coinsurance (30 days) <strong>Out-of-Network Provider</strong> <em>(You will pay the most)</em>: Not covered</td>
<td></td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the Summary Plan Description ( SPD) at [One.Walmart.com/Benefits](One.Walmart.com/Benefits).
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</thead>
<tbody>
<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>In-Network Provider (You will pay the least): Not covered</td>
<td>Non-Preferred brand drugs are not covered.</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Out-of-Network Provider (You will pay the most): 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>In-Network Provider (You will pay the least): 25% coinsurance (30 days)</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>Out-of-Network Provider (You will pay the most): 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>In-Network Provider (You will pay the least): $300 copay/visit, plus remaining annual deductible; coinsurance does not apply for emergency services.</td>
<td>If you are admitted to the hospital directly from the emergency room, the copay is waived.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>Out-of-Network Provider (You will pay the most): 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>In-Network Provider (You will pay the least): Office visits: $75 copayment/visit, deductible doesn’t apply; All other urgent care: 25% coinsurance</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>Out-of-Network Provider (You will pay the most): Not covered</td>
<td>Preauthorization may be required. *See the “Preauthorization” section in the Summary Plan Description.</td>
</tr>
</tbody>
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<tr>
<td></td>
<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></td>
<td></td>
<td></td>
<td></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></td>
<td></td>
<td></td>
<td></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</td>
<td>Home health care</td>
<td>25% coinsurance</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

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<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<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>special health needs</td>
<td></td>
<td>25% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td></td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Habilitation services</td>
<td></td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td></td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td></td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Hospice services</td>
<td></td>
<td>Not covered</td>
<td></td>
</tr>
</tbody>
</table>

**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** are limited to Applied Behavior Analysis therapy. **Preauthorization** may be required. *See the “Preauthorization” section in the SPD.

**Skilled nursing care** 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** 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** are limited to 365 days per illness.

*See the “Preauthorization” section in the SPD.

**Orthopedic shoes** when prescribed by a physician are limited to one pair per calendar year.

*See the “Preauthorization” section in the SPD.

**Hospice services** are limited to 365 days per illness.

*See the “Preauthorization” section in the SPD.

**Preauthorization** may be required.

**Children’s eye exam**
- No Charge
- Limited to screening that qualifies as preventive services. *See the “Preventive Care Program” section in the SPD for covered preventive services and applicable limitations.

**Children’s glasses**
- Not covered
- Glasses are limited when a certain medical diagnosis applies or form eye injury. See the “When Limited Benefits Apply to the Associates’ Medical Plan” section in the SPD.

**Children’s dental check-up**
- Not covered
- Dental check-ups are not covered under medical benefits; however, there may be additional other coverage under a separate dental plan.

**Excluded Services & Other Covered Services:**

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover</th>
<th>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>
<td>Glasses</td>
</tr>
<tr>
<td>Chiropractic care</td>
<td>Hearing aids</td>
</tr>
<tr>
<td>Dental care</td>
<td>Non-preferred brand drugs</td>
</tr>
<tr>
<td></td>
<td>Routine eye care</td>
</tr>
<tr>
<td></td>
<td>Weight loss programs</td>
</tr>
</tbody>
</table>
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) | Long-term care – Up to 60 days/disability period | 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) |
| Cosmet ic Surgery (limited to conditions that are considered reconstructive) | Non-Emergency Care when traveling Outside the U.S. (as provided by international business medical insurance policy) | Routine eye care (limited to services and limitations that are identified under the “Preventive Care” section of the SPD) |
| Infertility treatment (limited to the diagnosis & treatment of underlying medical condition.) | | 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): 如果需要中文的帮助，请拨打这个号码 1-800-421-1362.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijijig holne' 1-800-421-1362.

* 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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,750</td>
</tr>
<tr>
<td>Copayments</td>
<td>$90</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,700</td>
</tr>
</tbody>
</table>

**What isn't covered**

Limits or exclusions | $60

**The total Peg would pay is**: $4,600

### 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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,750</td>
</tr>
<tr>
<td>Copayments</td>
<td>$400</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,300</td>
</tr>
</tbody>
</table>

**What isn't covered**

Limits or exclusions | $20

**The total Joe would pay is**: $3,470

### 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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,600</td>
</tr>
<tr>
<td>Copayments</td>
<td>$300</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn't covered**

Limits or exclusions | $0

**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.

- **Albanian** - Për asistencë në gjuhën shqipe telefononi falas në 1-800-421-1362.
- **Amharic** - ሆኔታ እንጋገር እና እኔትና መንገወ መንግስት 1-800-421-1362 መልክ የስ.ወ.ና
- **Arabic** - للمساعدة في (اللغة العربية)، الراجع الاتصال على الرقم المجاني 1362-800-421-1362.
- **Armenian** - Լեզվի գործարարություն փաստաթղթաձև (հայերեն) զատար 1-800-421-1362 առանց գնով.
- **Bahasa Indonesia** - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-421-1362 tanpa dikenakan biaya.
- **Bantú-Kirundi** - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-800-421-1362 ku busa.
- **Bengali-Bangala** - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-800-421-1362-তে কল করুন।
- **Bisayan-Visayan** - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-421-1362 nga walay bayad.
- **Burmese** - ထို့အတွက် နောက်ဆိုးနောက် 1-800-421-1362.
- **Catalan** - Per rebrer assistència en (català), truqui al número gratuït 1-800-421-1362.
- **Chamorro** - Para ayuda gi fino' (Chamoru), ágang 1-800-421-1362 sin gástu.
- **Cherokee** - የንወቋ የትና ሃይስ ከመኽ የትና ይር የ обраща (CHW) ይብወጥስ 1-800-421-1362 ሊ经济社会 ይ ከወቋ ይ ከወቋ ሊ经济社会
- **Chinese** - 欲取得繁體中文語言協助，請撥打1-800-421-1362，無需付費。
- **Choctaw** - (Chahta) anumpa ya apela a chi l paya hinla 1-800-421-1362.
- **Cushite** - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-800-421-1362 irratti bilisaan bilbilaa.
- **Dutch** - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-421-1362.
- **French** - Pour une assistance linguistique en français appeler le 1-800-421-1362 sans frais.
- **French Creole** - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-421-1362 gratis.
- **German** - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-421-1362 an.
- **Greek** - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-421-1362 χωρίς χρέωση.
ગુજરાતીમાં ભાષામાં સહાય માટે કોઈપણ પણ અર્થ 1-800-421-1362 પર કોલ કરો.
Hawaiian - No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-800-421-1362. Kāki 'ole ia kēia kōkua nei.

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

Hmong - Maka enyemaka asus na Igbo kpọọ 1-800-421-1362 na akwughj ugwo ọ buña.

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, può 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 ké gbo-kpá-kpá dyé pidyi qé Basoó-wuqúün wée, qa 1-800-421-1362

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-421-1362 번으로 전화해 주십시오.

Kru-Bassa - Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-421-1362 ilo ejelok wōnān.

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

Laotian - Hoọng palien sawas en soum kawewe ni omw loka Ponape koahl 1-800-421-1362 ni sohte isais.

Marathi - तीलभाषा (मराठी) सहाय्यासाठी 1-800-421-1362 क्रमांकावरकोणत्याहीखर्चीशिवायकॉलकरा.

Marshallese - Ohng palien sawas en soum kawewe ni omw loka Ponape koahl 1-800-421-1362 ni sohte isais.

Mon-Khmer, Cambodian - 1-800-421-1362 ni sohte isais.

Navajo - T’áá shi shizaad kehjí bee shiká a’doowol ninizingo Diné kehjí koji’ t’áá jiik’e hólne’ 1-800-421-1362

Nepali - (नेपाली) मा लिःशुलक भाषा सहायता पाउनका लागि 1-800-421-1362 मा फोन गर्नौहोस्।

Nilotic-Dinka - Tën kuocny ê thok ê Thuorjān col 1-800-421-1362 kecín ayōć.

Norwegian - For språkkassistanse på norsk, ring 1-800-421-1362 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-421-1362 ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।


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

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-421-1362.
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](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)
Servicios de interprete están disponibles gratis. 1-800-421-1362.

Русский
Переводческие услуги оказываются бесплатно. 1-800-421-1362.

Español
Servicios de interpretación están disponibles de manera gratuita. 1-800-421-1362.

Af-Soomaali
Adeegyada Turjumaanka waxaa lagu hela karaa kharash la’aan. 1-800-421-1362.

Română
Serviciile de interpretare sunt disponibile gratuit. 1-800-421-1362.

한국어
통역 서비스를 무료로 이용하실 수 있습니다. 1-800-421-1362.

日本語
通訳サービスは無料でご利用いただけます。1-800-421-1362.