



Arkansas
BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

Benefit Summary

ARKANSAS TECH UNIVERSITY

BC 4000-70_E - (1)

WELCOME

Arkansas Blue Cross and Blue Shield is pleased to be your health insurance provider. For more than 75 years, Arkansas Blue Cross has been a name Arkansans have trusted. This Benefit Summary gives you an overview of your health coverage. *This summary is not your policy.* You will receive a Benefit Certificate that describes your complete health insurance coverage in greater detail.

SAVE MONEY WITH YOUR HEALTH INSURANCE

Most of us are interested in saving money, and when you use the services of in-network providers, you will pay less money out of pocket. Please take a moment to review this important information about your coverage.

Provider: You will see the term health care provider throughout this document. Providers are doctors, hospitals and others who offer medical services, such as labs or radiology clinics.

In-network providers: In-network health care providers are part of a group of participants who have agreed to give you a discount.

- In-network providers bill according to our agreement

- In-network providers participate in discounts for your medical services
- We pass the savings on to you, resulting in lower out-of-pocket expenses.

Please check to see that your health care provider is in your network.

Out-of-network providers: Out-of-network health care providers may not offer discounted services to our members.

- Out-of-network providers follow their own billing rules for services
- Your out-of-pocket expenses will be greater when you use an out-of-network provider
- Your health insurance policy is set up with a higher coinsurance.

Always check the network status of a provider that your doctor may refer you to for additional care. If you're referred to an out-of-network provider by an in-network provider, you still may have to pay higher costs.

Medical emergency: In a medical emergency, go directly to the nearest hospital. Medical services are covered at your plan's in-network deductible and health coinsurance amounts. Please note, if a visit to the hospital emergency room isn't a medical emergency, then in-network coverage may not be allowed. This can result in higher out-of-pocket costs. See your Benefit Certificate for a complete description of medical emergencies.

At Arkansas Blue Cross, your continued good health is our main concern.

HOW TO FIND AN IN-NETWORK PROVIDER

Always use your member number (on your ID card) to ensure the proper network when searching online.

For a list of in-network providers, visit us online at: [arkansasbluecross.com/find a doctor](https://arkansasbluecross.com/find-a-doctor)

Your Provider Network is: **True Blue** or call Customer Service at:

501-378-2010 or **1-800-238-8379**

Important Note: For your protection, we want you to know that some doctors and hospitals may require up-front payment of your anticipated portion of the deductible and coinsurance fees. For some health policies, out-of-state providers may not be included at in-network rates. Check your Evidence of Coverage for your plan details.

Important Disclaimer from Arkansas Blue Cross and Blue Shield

This document is intended only to highlight your benefits and should not be relied on to fully determine coverage. **Some of the above services are subject to visit, day and/or dollar limits.** Please refer to your Benefit Certificate for a full explanation of your benefits, the limitations of these benefits and the services that are not covered. If this document conflicts in any way with the policy issued to your employer, the policy shall prevail.

Descriptions

Your Portion

Individual Deductible: A dollar amount that you pay for healthcare services before the health plan begins to pay. Every policy has an individual or family deductible. If you are the only person on your policy, then you will pay for healthcare costs covered by your plan until you meet your individual deductible. Family deductibles work differently.

\$4,000 In-network
\$12,000 Out-of-network

Family Deductible: If you or anyone in your family meets the individual deductible, then your health plan will begin to pay a portion of medical expenses for that person for that calendar year (also called coinsurance). However, when the family deductible is met by any combination of family members, coinsurance will pay on all family members. *Continues on page four.*

\$8,000 In-network
\$24,000 Out-of-network

Coinsurance: A percentage of all remaining eligible medical expenses that is your responsibility to pay after your deductible has been satisfied.

Copayment: The amount you're required to pay to a preferred provider for covered medical expenses.

Annual Limit on Cost Sharing: The claims amount that you must pay in a calendar year before you're no longer expected to pay copayments, deductible or coinsurance for the remainder of the year. The annual limitation on cost sharing is outlined in the Schedule of Benefits.

Annual Limit on Cost Sharing

In-Network	Individual \$7,000	Family \$14,000
Out-of-Network*	\$24,000	\$48,000

*Annual limit on out-of-network costs does not include copayments.

Service Type**	Your Cost In-network coinsurance	Your Cost Out-of-network coinsurance
Professional Services		
Primary care physician visit Copayment amount \$40	0%	50%
Specialty physician visit (Coinsurance may apply to additional services) Copayment amount \$80	30%	50%
Adult preventive services	0%	20%
Children's preventive services	0%	20%
Professional fees for inpatient surgical and medical services	30%	50%
Professional fees for outpatient surgical and medical services	30%	50%
Hospital and Other Medical Facility Services		
Inpatient services	30%	50%
Outpatient services (Includes surgery, diagnostics, lab and X-ray)	30%	50%
Emergency room visit	30%	30%
Maternity and obstetrics	30%	50%
Therapeutic Services		
Inpatient (limited to 60 days)	30%	50%
Outpatient (limited to 30 visits total) ▪ Physical, occupational and speech therapy ▪ Chiropractic Copayment amount \$40 Copayment amount \$80	0% 30%	50% 50%
Other Services		
Durable medical equipment***	30%	50%
Diabetic supplies	30%	50%
Mental health	30%	50%
Ambulance services — Ground	30%	30%
— Air	30%	30%

Additional fees may apply. Please check your Benefit Certificate. * Prior approval required for durable medical equipment that exceeds \$5,000.

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Your Drug Coverage

Your prescription drug benefit is an important part of your health coverage. There are often lower-cost options available; ask your doctor for alternatives.

All **preventive** prescription drugs are covered in full.

Generic drugs will cost less and have lower copayments. Selecting generic

drugs is a way to save money on your overall healthcare expenses.

Preferred brand-name drugs will cost less and will have lower copayments than **non-preferred brand-name** drugs.

Non-Preferred brand-name drugs are more expensive drugs. **Specialty** drugs typically require defined handling and

home storage demands, crucial patient education and careful monitoring.

Your coverage features a mail order option that may offer savings on drugs that have been prescribed on an ongoing basis. Check your [\[Benefit Certificate/Certificate of Coverage/Schedule of Benefits\]](#) for details.

Copayments by Category

**One copayment per 100-day supply*

Preventive	Generic	Preferred Brand	Non-preferred Brand	Specialty
Covered in full	\$30.00	\$70.00	\$135.00	\$270.00
Mail order*	\$90.00	\$210.00	\$405.00	

Family Deductible Details

Bob and Sue Thompson have one child, Margo. Their family deductible is \$3,000 and the individual deductible is \$1,500. Sue paid \$1,200 in covered healthcare expenses. Bob paid \$1,100 in covered healthcare expenses. Margo paid \$700 in covered healthcare expenses. None of the Thompson's met the individual deductible. However, their family's total expense \$3,000 (meeting the family deductible) and the health plan will begin paying coinsurance for all family members.

Other Member Services

Blueprint Portal – your personal online self-service center – allows you access to a wealth of information from the home page of our website at arkansasbluecross.com. Access or register for *Blueprint Portal* through the sign in box on the home page.



Questions?

We hope you'll call us with any questions or concerns.

Our office hours are Monday through Friday from 8 a.m. to 4:30 p.m. (CST).

Customer Service Number: **501-378-2010** or **1-800-238-8379**

More information can be found on our website at: arkansasbluecross.com

Local Sales and Service Center: Arkansas Blue Cross and Blue Shield
416 S University Ave
Suite 110
Little Rock, AR 72205



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MPI #3229 11/15

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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, call 1-800-238-8379 or visit us at www.arkansasbluecross.com/employers/administrative/benefit-certificates. 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.arkansasbluecross.com/sbc-glossary> or call 1-800-238-8379 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	For in-network <u>providers</u> \$4,000 individual / \$8,000 family ; for <u>out-of-network providers</u> \$12,000 individual / \$24,000 family.	Generally, you must pay all of 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> , <u>prescription drugs</u> , and primary care 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 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For in-network <u>provider</u> - \$7,000 individual / \$14,000 family. For <u>out-of-network providers</u> - \$24,000 individual/ \$48,000 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> ?	Out-of-network <u>Deductible</u> , <u>premiums</u> , <u>balance-billing</u> charges, 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 https://secure.arkansasbluecross.com/providerdirectory/trueblueppo.aspx or call 1-800-238-8379 for a list of In-network <u>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</u> charge 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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a healthcare provider's office or clinic	Primary care visit to treat an injury or illness	\$40 <u>copay</u> /visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	---none---
	<u>Specialist</u> visit	\$80 <u>copay</u> /visit	50% <u>coinsurance</u>	---none---
	<u>Preventive care/screening/immunization</u>	No Charge	30% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	---none---
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	---none---
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.arkansasbluecross.com/members/pharmacy-resources .	Generic drugs	Retail \$30 <u>copay</u> /prescription Mail \$90 <u>copay</u> /prescription; <u>deductible</u> does not apply	Not Covered	Covers up to a 30-day supply (retail subscription)Mail order is covered
	Preferred brand drugs	Retail \$70 <u>copay</u> /prescription Mail \$210 <u>copay</u> /prescription; <u>deductible</u> does not apply	Not Covered	Covers up to a 30-day supply (retail subscription)Mail order is covered
	Non-preferred brand drugs	Retail \$135 <u>copay</u> /prescription Mail \$405 <u>copay</u> /prescription; <u>deductible</u> does not apply	Not Covered	Covers up to a 30-day supply (retail subscription)Mail order is covered
	<u>Specialty drugs</u>	Retail \$270 <u>copay</u> /prescription; <u>deductible</u> does not apply	Not Covered	Prior authorization, step therapy or quantity limitations may apply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	---none---
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	---none---
If you need immediate medical attention	<u>Emergency room care</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	---none---
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	---none---
	<u>Urgent care</u>	\$80 <u>copay</u> /visit	50% <u>coinsurance</u>	---none---

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	---none---
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	---none---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	3 visits free before <u>coinsurance</u> applies, thereafter, <u>coinsurance</u> will apply for all other outpatient services and procedures; PCP <u>copay</u> applies to office visits
	Inpatient services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	---none---
If you are pregnant	Office visits	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Coverage for routine ultrasounds limited to 1; Maternity care may include tests and services described elsewhere in the SBC
	Childbirth/delivery professional services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	---none---
	Childbirth/delivery facility services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	---none---
If you need help recovering or have other special health needs	<u>Home health care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Coverage is limited to 40 visits/calendar year
	<u>Rehabilitation services</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Outpatient services limited to 30 visits/person/calendar year
	<u>Habilitation services</u>	Not Covered	Not Covered	None
	<u>Skilled nursing care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 30 days/calendar year
	<u>Durable medical equipment</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	---none---
	<u>Hospice services</u>	30% <u>coinsurance</u>	50% <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	None
	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.)

- | | | |
|--------------------|-------------------------|------------------------|
| • Acupuncture | • Habilitation services | • Routine foot care |
| • Cosmetic Surgery | • Hearing aids | • Weight loss programs |
| • Dental Care | • Long term care | |
| • Eye exam | • Private-duty nursing | |
| • Glasses | • Routine Eye Care | |

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

- | | | |
|--|--|--|
| • Bariatric Surgery (Subject to Prior Authorization) | • Chiropractic care (Outpatient rehabilitation services limited to 30 visits/person/calendar year) | • Infertility treatment |
| | | • Non-emergency care when traveling outside of U.S. (Subject to discretion of the company) |

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: Arkansas Insurance Department at 1-800-852-5494, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or contact the plan at 1-800-238-8379. 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 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 the plan at 1-800-238-8379. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. The contact information is:

Arkansas Insurance Department
1 Commerce Way, Suite 102, Little Rock, AR 72202
Telephone 1-800-852-5494, Email address: insurance.consumers@arkansas.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 (Español): Para obtener asistencia en Español, llame al 1-844-662-2276.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-662-2276.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-844-662-2276.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-844-662-2276.

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 **plan's** overall **deductible** **\$4,000**
- **Specialist copayment** **\$80**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$4,000
Copayments	\$200
Coinsurance	\$2,500
<i>What isn't covered</i>	
Limits or exclusions	\$70
The total Peg would pay is	\$6,770

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

- The **plan's** overall **deductible** **\$4,000**
- **Specialist copayment** **\$80**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,600
Copayments	\$2,400
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$4,060

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

- The **plan's** overall **deductible** **\$4,000**
- **Specialist copayment** **\$80**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,400
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,600

NOTICE OF LANGUAGE ASSISTANCE, AUXILIARY AIDS/SERVICES AND NON-DISCRIMINATION NOTICE

We provide free language assistance, appropriate auxiliary aids and services, and reasonable modifications to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, written information in various formats (large print, audio, accessible electronic formats, other formats), and language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, call or contact Customer Service at 1-800-238-8379 (TTY:771) or Civil Rights Coordinator.

ATTENTION: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in assessable formats are available free of charge. Call 1-800-238-8379 (TTY: 711) or speak to your provider.

Spanish: ATENCIÓN: Disponemos de servicios gratuitos de asistencia lingüística. También hay disponibles de forma gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 1-800-238-8379 (TTY: 711) o hable con su proveedor.

Chinese Simplified: 注意：提供免费语言服务。此外，免费提供适合残障人士使用的辅助和支持服务。请致电 1-800-238-8379 (TTY: 711) 或联系您的服务提供商。

Chinese Traditional: 注意：我們提供免費的語言協助服務，以及免費的適當輔助工具和其他服務，讓您能夠獲得無障礙格式的資訊。請撥打 1-800-238-8379 (TTY: 711) 或諮詢您的服務提供者。

Tagalog: PAUNAWA: Available para sa iyo ang mga libreng serbisyo sa tulong sa wika. Available rin nang walang bayad ang mga naaangkop na auxiliary na tulong at serbisyo para magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-238-8379 (TTY: 711) o makipag-usap sa iyong provider.

French: ATTENTION : Des services d'assistance linguistique sont gratuitement mis à votre disposition. Des aides et services auxiliaires appropriés visant à vous informer dans des formats accessibles sont également mis à votre disposition gratuitement. Appelez le 1 800 238 8379 (TTY : 711) ou discutez avec votre prestataire.

Vietnamese: CHÚ Ý: Các dịch vụ hỗ trợ ngôn ngữ sẽ được cung cấp miễn phí cho quý vị. Các dịch vụ và hỗ trợ giao tiếp phù hợp nhằm cung cấp thông tin ở các định dạng dễ tiếp cận cũng được cung cấp hoàn toàn miễn phí. Hãy gọi 1-800-238-8379 (TTY: 711) hoặc trao đổi với nhà cung cấp của quý vị.

German: HINWEIS: Ihnen stehen kostenlose Sprachmittlungsdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zum barrierefreien Zugang zu Informationen stehen ebenfalls kostenfrei zur Verfügung. Rufen Sie 1-800-238- 8379 (TTY: 711) an oder sprechen Sie mit Ihrem Leistungserbringer.

Korean: 주의: 무료 언어 지원 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 도구와 서비스도 무료로 제공됩니다. 1-800-238-8379 (TTY: 711) 번으로 전화하거나 담당 서비스 제공자에게 문의하십시오.

Russian: ВНИМАНИЕ! Вам доступны бесплатные услуги языковой поддержки. Приемлемые вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-238-8379 (TTY: 711) или обратитесь к своему поставщику услуг.

Arabic: ملاحظة: خدمات المساعدة اللغوية متاحة لك مجاناً، كما أن وسائل وخدمات المساعدة الإضافية المناسبة لتوفير المعلومات بصيغ يسهل عليك الوصول إليها متاحة مجاناً أيضاً. يرجى الاتصال على الرقم: 1-800-238-8379 (TTY: 711) أو التحدث إلى مقدم الرعاية

Hindi: ध्यान दें: आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध हैं। आसान फॉर्मेट में सूचना उपलब्ध कराने के लिए उचित सहायक साधन और सेवाएं भी निःशुल्क उपलब्ध हैं। 1-800-238-8379 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

Italian: ATTENZIONE: Ha a disposizione servizi di assistenza linguistica gratuiti. Potrà usufruire gratuitamente anche di sussidi e servizi ausiliari appropriati per ottenere le informazioni in formati accessibili. Chiami il numero 1-800-238-8379 (TTY: 711) o chiedi al suo operatore sanitario.

Portuguese: ATENÇÃO: Serviços gratuitos de assistência linguística estão disponíveis para você. Ajudas e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-238-8379 (TTY: 711) ou fale com seu provedor.

French Creole: ATANSYON: Genyen sèvis asistans lang gratis disponib pou ou. Epitou, genyen lòt èd ak sèvis apwopriye disponib gratis pou ede moun jwenn enfòmasyon nan yon fòm ki aksesib. Rele 1-800-238-8379 (TTY: 711) oswa pale ak founisè w la.

Polish: UWAGA: może Pan/Pani skorzystać z bezpłatnych usług pomocy językowej. Odpowiednie dodatkowe pomoce i usługi w zakresie zapewniania dostępu do informacji w przystępnym formacie również są dostępne bezpłatnie. Prosimy dzwonić pod numer 1-800-238-8379 (TTY: 711) lub porozmawiać z lekarzem.

Japanese: 注意: 無料の言語サポートサービスをご利用いただけます。アクセシブルなフォーマットで情報を提供するための適切な援助やサービスも無料でご利用いただけます。1-800-238-8379 (TTY: 711) にお電話いただくか、医療提供者にご相談ください

NON-DISCRIMINATION NOTICE

Our Company complies with applicable federal and state civil rights laws and does not discriminate, exclude, or treat people differently on the basis of race, color, national origin, age, disability, or sex.

If you believe that we have failed to provide these language assistance or auxiliary aids and services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex.

Civil Rights Coordinator

601 Gaines Street, Little Rock, AR 72201

Phone: 1-844-662-2276 (TTY: 711)

You can file a grievance in person, by mail, or by email. If you need help filing a grievance our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201

Phone: 1-800-368-1019; TDD: 1-800-537-7697

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.