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 1-833-613-2262 (TTY 1-844-214-2471). 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 call 1-833-613-2262 (TTY 1-844-214-2471) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$8,000 / individual or $16,000 / family	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, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, primary care, specialist, urgent care office visits, generic drugs, and children's eye exams and glasses are covered (may require a copayment) before you meet your deductible.	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?	Yes. $400 for prescription drug coverage (except generic drugs). There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$8,700 individual / $17,400 family	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 and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See https://amerihealthcaritasnext.healthsparq.com/healthsparq/public/#/one/city=&state=&postalCode=&country=&insurerCode=ACNEXT_I&br	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.

Important Questions	Answers	Why This Matters:
	andCode=ACNEXT&alphaPrefix=&bcbsaProductId=&productCode=NCEXv or call 1-833-613-2262 for a list of network providers.	
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

 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
		Network Provider (You will pay the least)	Out-of-Network Provider (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	$60 copay/office visit; deductible does not apply.	Not covered	First three visits covered at no charge. Virtual Visits from AmeriHealth Caritas Next designated virtual care providers covered in full, deductible does not apply. Refer to the policy for more information about Virtual Care Services.
	Specialist visit	$150 copay/visit; deductible does not apply	Not covered	None.
	Preventive care/screening/ immunization	No Charge	Not covered	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.
If you have a test	Diagnostic test (x-ray, blood work)	50% coinsurance	Not covered	Prior authorization may be required. Covered No limit.
	Imaging (CT/PET scans, MRIs)	50% coinsurance	Not covered	Prior authorization may be required. Covered No limit.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://client.formularynavigat	ACA tier (preventative drugs)	No Charge	Not covered	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail-order prescription). Copay shown is per retail
	Preferred generic drugs	$15 copay/prescription; deductible does not apply	Not covered	
	Non-preferred generic drugs	$25 copay/prescription; deductible does not	Not covered	

[* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
or.com/Search.aspx?siteCode=6186787868		apply		prescription. Mail order copay is 2.5 times retail copay. Coinsurance shown is for both retail and mail order prescriptions. Prior authorization / step therapy may be required.
	Preferred brand drugs	$40 copay/prescription after prescription drug deductible	Not covered	
	Non-preferred brand drugs	50% after prescription drug deductible	Not covered	
	Specialty drugs	50% after prescription drug deductible	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% coinsurance	Not covered	Prior authorization may be required. Covered No limit.
	Physician/surgeon fees	50% coinsurance	Not covered	Prior authorization may be required. Covered No limit.
If you need immediate medical attention	Emergency room care	50% coinsurance	50% coinsurance	Copay or Coinsurance amount due for each ER visit after satisfaction of the plan deductible amount. You pay the same level as In-network if it is an emergency as defined in your plan, otherwise Not Covered.
	Emergency medical transportation	50% coinsurance	50% coinsurance	Prior authorization may be required for non-emergency situations.
	Urgent care	$120 copay/visit; deductible does not apply	Not covered	Out of network Urgent Care services are covered when network providers are temporarily unavailable or inaccessible and if the services are for an urgent condition as defined in your plan, otherwise Not Covered.
If you have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance	Not covered	Prior authorization may be required. Covered No limit.
	Physician/surgeon fees	50% coinsurance	Not covered	Prior authorization may be required. Covered No limit.
If you need mental health, behavioral health, or substance	Outpatient services	50% coinsurance	Not covered	Prior authorization may be required. Covered No limit. (PCP and other practitioner visits do not require prior

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
abuse services				authorization).
	Inpatient services	50% coinsurance	Not covered	Prior authorization may be required. Covered No limit.
If you are pregnant	Office visits	$60 copay/visit; deductible does not apply	Not covered	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	50% coinsurance	Not covered	
	Childbirth/delivery facility services	50% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	50% coinsurance	Not covered	Prior authorization may be required. Covered No limit.
	Rehabilitation services	50% coinsurance	Not covered	Prior authorization may be required. Combined 30 visits/year for physical/occupational therapy and chiropractic services. 30 visits/year for speech therapy.
	Habilitation services	50% coinsurance	Not covered	Prior authorization may be required. Combined 30 visits/year for physical/occupational therapy and chiropractic services. 30 visits/year for speech therapy.
	Skilled nursing care	50% coinsurance	Not covered	Prior authorization may be required. Limits may apply.
	Durable medical equipment	50% coinsurance	Not covered	Prior authorization may be required. Limits may apply.
	Hospice services	50% coinsurance	Not covered	Prior authorization may be required. Covered No limit.
If your child needs dental or eye care	Children's eye exam	No Charge	Not covered	Limited to 1 exam per year.
	Children's glasses	No Charge	Not covered	Limited to 1 pair of Children's glasses per year.
	Children's dental check-up	Not covered	Not covered	-----None-----

[* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].]

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.)

- Abortion (except in case of rape, incest, or when life of mother is endangered)
- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside of the U.S.
- Routine eye care (Adult)
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care (Limited to 30 specialist visits per year combined with occupational and physical therapy)
- Hearing aids (Limited to once every 36 months)
- Infertility treatment (Limited to 3 treatments per lifetime)
- Private-duty nursing
- Routine foot care (Limited to diabetes care only)

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov, or North Carolina Department of Insurance, 1201 Mail Service Center, Raleigh, NC 27699-1201, Phone No. 1-800-546-5664 or 1-919-807-6750. 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: North Carolina Department of Insurance at 1201 Mail Service Center, Raleigh, NC 27699-1201, Phone no. 1-800-546-5664 or ncdoi.com.

Additionally, a consumer assistance program can help you file your appeal. Contact North Carolina Department of Insurance, Health Insurance Smart NC at 1-877-885-0231 or ncdoi.com.

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Not Applicable

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 [1-833-613-2262].

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [1-833-613-2262].

[* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码[1-833-613-2262].

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [1-833-613-2262].

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

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.

[* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].]

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	**$8,000**
Specialist *[cost sharing]*	**$120**
Hospital (facility) *[cost sharing]*	**50%**
Other *[cost sharing]*	**50%**

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	
Deductibles	$8,000
Copayments	$50
Coinsurance	$700
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$8,700**

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

The plan's overall deductible	**$8,000**
Specialist *[cost sharing]*	**$120**
Hospital (facility) *[cost sharing]*	**50%**
Other *[cost sharing]*	**50%**

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	
Deductibles	$1,300
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2500**

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

The plan's overall deductible	**$8,000**
Specialist *[cost sharing]*	**$120**
Hospital (facility) *[cost sharing]*	**50%**
Other *[cost sharing]*	**50%**

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	
Deductibles	$2,500
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2800**

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

AmeriHealth Caritas

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English: You can get this material and other plan information in large print for free. To get materials in large print, call Member Services at **1-833-613-2262 (toll free) (TTY 1-844-214-2471)**.

If English is not your first language, we can help. Call **1-833-613-2262 (toll free) (TTY 1-844-214-2471)**. You can ask us for the information in this material in your language. We have access to interpreter services and can help answer your questions in your language.

Spanish: Puede obtener este material y otra información del plan en letra grande de manera gratuita. Para obtener materiales en letra grande, llame a Servicios al Miembros al **1-833-613-2262 (sin cargo) (TTY 1-844-214-2471)**.

Si el inglés no es su idioma principal, podemos ayudarlo. Llame al **1-833-613-2262 (sin cargo) (TTY 1-844-214-2471)**. Puede solicitarnos recibir la información de este material en su idioma. Tenemos acceso a servicios de interpretación y podemos responder sus preguntas en su idioma.

Simplified Chinese: 您可以免费获取本资料内容及其他计划相关信息的大号字体版。如需获取以大号字体印刷的资料，请致电会员服务部 **1-833-613-2262 (免费) (TTY 1-844-214-2471)**。

如果英语不是您的第一语言，我们可以提供帮助。请致电 **1-833-613-2262 (免费) (TTY 1-844-214-2471)**。您可以使用您的语言向我们索取本资料中的信息。我们可以提供口译服务，可以用您的语言解答您的问题。

Vietnamese: Quý vị có thể nhận tài liệu này cùng các thông tin khác về chương trình dưới dạng bản in cỡ lớn miễn phí. Để nhận được bản in cỡ lớn của tài liệu, vui lòng gọi cho ban Dịch Vụ Hội Viên theo số **1-833-613-2262 (điện thoại miễn phí) (TTY 1-844-214-2471)**.

Chúng tôi có thể giúp đỡ quý vị nếu Tiếng Anh không phải ngôn ngữ chính của quý vị. Hãy gọi **1-833-613-2262 (điện thoại miễn phí) (TTY 1-844-214-2471)**. Quý vị có thể yêu cầu chúng tôi cung cấp các thông tin trong tài liệu này được trình bày bằng ngôn ngữ của quý vị. Chúng tôi có quyền tiếp cận với dịch vụ thông dịch viên và có thể giúp trả lời các thắc mắc của quý vị bằng ngôn ngữ của quý vị.

Korean: 본 자료 및 기타 보험 플랜 정보를 확대 문자로 무료로 받아보실 수 있습니다. 본 자료를 확대 문자로 받아보고자 하시는 경우, **1-833-613-2262 (수신자 부담) (TTY 1-844-214-2471)**번으로 회원 서비스에 연락주시기 바랍니다.

영어가 모국어가 아닌 경우, 도움을 드릴 수 있습니다. **1-833-613-2262 (수신자 부담) (TTY 1-844-214-2471)**번으로 연락주십시오. 본 정보를 귀하의 언어로 요청하실 수 있습니다. 당사는 통역 서비스를 통해 귀하의 질문에 대해 귀하의 언어로 답변해 드릴 수 있습니다.

French: Vous pouvez obtenir ce document et d'autres renseignements gratuitement en gros caractères. Pour ce faire, appelez l'équipe de services aux adhérents au **1-833-613-2262 (numéro gratuit) (TTY 1-844-214-2471)**.

Si l'anglais n'est pas votre langue maternelle, nous pouvons vous aider. Appelez au **1-833-613-2262 (numéro gratuit) (TTY 1-844-214-2471)**. Vous pouvez nous demander de vous fournir les renseignements figurant dans ce document dans votre langue. Nous avons accès à des services d'interprétation pour répondre à vos questions dans votre langue.

Arabic:

العربية: يمكنك الحصول على هذه المادة ومعلومات أخرى عن الخطة في مطبوعة كبيرة مجانًا. للحصول على مواد مطبوعة كبيرة اتصل بخدمات الأعضاء على **1-833-613-2262 (الهاتف المجاني) (TTY 1-844-214-2471)**.

إذا لم تكن اللغة الإنجليزية لغتك الأولى فيمكننا مساعدتك. اتصل بالرقم **1-833-613-2262 (الهاتف المجاني) (TTY 1-844-214-2471)**. يمكنك أن تطلب منا المعلومات الموجودة في هذه المادة بلغتك. لدينا إمكانية الوصول إلى خدمات مترجمين فوريين ويمكننا المساعدة في الإجابة عن أسئلتك بلغتك.

Hmong: Koj muaj peev xwm tau txais cov ntaub ntawv no thiab lwm cov lus qhia txog pawg kho mob sau ua ntawv luam loj pub dawb. Yog koj xav tau cov ntaub ntawv sau ua ntawv luam loj, hu rau Lub Thawj Fab Saib Xyuas Hauj Lwm Kev Pab Cuam Rau Tswv Cuab ntawm **1-833-613-2262 (hu dawb) (TTY 1-844-214-2471)**.

Yog tias lus As Kiv tsis yog koj thawj hom lus, peb muaj peev xwm pab tau. Hu rau **1-833-613-2262 (hu dawb) (TTY 1-844-214-2471)**. Koj muaj peev xwm nug peb tau txog rau cov lus qhia nyob rau hauv cov ntaub ntawv no hais ua koj hom lus. Peb muaj kev txuas cuag tau rau cov kev pab cuam fab kev txhais lus thiab muaj peev xwm pab teb tau koj cov lus nug hais ua koj hom lus.

Russian: Крупношрифтовые издания как данного материала, так и другой информации о страховом плане вы можете получить бесплатно. Чтобы получить экземпляр, напечатанный крупным шрифтом, обратитесь в отдел обслуживания участников плана по телефону **1-833-613-2262 (Бесплатный номер) (TTY 1-844-214-2471)**.

Если ваш родной язык не английский, мы можем помочь. Позвоните по телефону **1-833-613-2262 (Бесплатный номер) (TTY 1-844-214-2471)**. Вы можете попросить нас предоставить вам изложенную в данном документе информацию на вашем языке. Мы имеем доступ к услугам устных переводчиков и можем ответить на ваши вопросы на вашем родном языке.

Tagalog: Maaari mong makuha ang babasahing na ito at iba pang impormasyon sa plano sa malaking print nang libre. Upang makakuha ng mga babasahin sa malaking print, tumawag sa Member Services (Mga Serbisyo para sa Miyembro) sa **1-833-613-2262 (walang bayad) (TTY 1-844-214-2471)**.

Kung hindi mo unang wika ang Ingles, maaari kaming makatulong. Tumawag sa **1-833-613-2262 (walang bayad) (TTY 1-844-214-2471)**. Maaari kang humingi ng impormasyon sa amin sa babasahing ito sa iyong wika. Mayroon kaming access sa mga serbisyo ng tagapagsalin at maaaring tumulong sa pagsagot sa iyong mga katanungan sa iyong wika.

Gujarati: તમે આ સાહિત્ય અને યોજનાની અન્ય માહિતી વિના મૂલ્યે મોટી પ્રિન્ટમાં મેળવી શકો છો. મોટી પ્રિન્ટમાં સાહિત્ય મેળવવા માટે, મેમ્બર સર્વિસીસને અહીં કૉલ કરો **1-833-613-2262 (toll free) (TTY 1-844-214-2471)**. જો ઇંગ્લીશ તમારી પ્રથમ ભાષા ન હોય, તો અમે મદદ કરી શકીએ છીએ. અહીં કૉલ કરો **1-833-613-2262 (toll free) (TTY 1-844-214-2471)**. તમે આ પુસ્તિકાની માહિતી તમારી ભાષામાં મેળવવા અમને પૂછી શકો છો. અમારી પાસે દુભાષિયા સેવાઓ ઉપલબ્ધ છે અને તમારી ભાષામાં તમારા પ્રશ્નોના જવાબ આપવામાં અમે મદદ કરી શકીએ છીએ.

Mon-Khmer: អ្នកអាចទទួលបានឯកសារនេះនិងព័ត៌មានគម្រោងផ្សេងៗទៀតជាអក្សរពុម្ពធំដោយមិនគិតថ្លៃ។ ដើម្បីទទួលបានឯកសារជាអក្សរពុម្ពធំ សូមហៅទៅកាន់សេវាកម្មសមាជិកតាមរយៈលេខ **1-833-613-2262 (លេខទូរស័ព្ទហៅដោយមិនគិតថ្លៃ) (TTY 1-844-214-2471)**។ ប្រសិនបើអ៊ុំង់គ្លេសមិនមែនជាភាសាទីមួយរបស់អ្នក យើងអាចជួយ បាន។ សូមហៅទៅកាន់លេខ **1-833-613-2262 (លេខទូរស័ព្ទហៅដោយមិនគិតថ្លៃ) (TTY 1-844-214-2471)**។ អ្នកអាចស្នើសុំយើងខ្ញុំនូវឯកសារនេះជាភាសារបស់អ្នក។ យើងមានសិទ្ធិចូលប្រើសេវាបកប្រែ និងអាចជួយអ្នកឆ្លើយសំណួររបស់អ្នកជាភាសារបស់អ្នក ។

German: Sie können dieses Material und andere Planinformationen kostenlos in Großdruck erhalten. Um Materialien in Großdruck zu erhalten, rufen Sie den Mitgliederservice unter **1-833-613-2262 (gebührenfrei) (TTY 1-844-214-2471)** an.

Falls Englisch nicht Ihre Muttersprache ist, helfen wir Ihnen gerne. Rufen Sie an: **1-833-613-2262 (gebührenfrei) (TTY 1-844-214-2471)**. Sie können die Informationen in diesem Material bei uns in Ihrer Sprache erhalten. Wir haben Zugang zu Dolmetscher-Diensten und können Ihre Fragen in Ihrer Sprache beantworten.

Hindi: आप को यह साहित्य और अन्य योजना जानकारी बड़े प्रिंट में मुफ्त प्राप्त हो सकती है। बड़े प्रिंट में यह साहित्य प्राप्त करने के लिए, **1-833-613-2262 (toll free) (TTY 1-844-214-2471)** पर सदस्य सेवाओं को कॉल करें।

यदि अंग्रजी आपकी मातृभाषा नहीं है, हम आपकी सहाय्यता कर सकते हैं। **1-833-613-2262 (toll free) (TTY 1-844-214-2471)** पर कॉल करें। आप अपनी भाषा में इस हस्तपुस्तिका की जानकारी मांग सकते हैं। हमारे पास दुभाषिया सेवाएं उपलब्ध हैं और आपकी भाषा में आपके सवालों के जवाब देने में सहाय्यता कर सकते हैं।

Laotian: ທ່ານສາມາດຮັບເອກະສານນີ້ ແລະຂໍ້ມູນແຜນການອື່ນໆ ເປັນ ຕົວຫນັງສືໃຫຍ່ຟຣີ. ຂໍຮັບເອກະສານ ເປັນຕົວຫນັງສືຂະຫນາດໃຫຍ່ ໂທຫາ ສູນບໍລິການສະມາຊິກທີ **1-833-613-2262 (toll free) (TTY 1-844-214-2471)**. ຖ້າພາສາອັງກິດບໍ່ແມ່ນພາສາທຳອິດ ຂອງທ່ານ, ພວກເຮົາສາມາດຊ່ວຍ ທ່ານໄດ້. ໂທ **1-833-613-2262 (toll free) (TTY 1-844-214-2471)**. ທ່ານສາມາດ ສອບຖາມຂໍ້ມູນໃນເອກະສານນີ ເປັນພາສາຂອງທ່ານໄດ້. ພວກເຮົາ ມີບໍລິການນາຍພາສາແລະສາມາດ ຊ່ວຍຕອບຄຳຖາມຂອງທ່ານເປັນ ພາສາຂອງທ່ານ.

Japanese: この資料とその他のプラン情報は拡大版で無料にて提供致します。拡大版を請求するには、メンバーサービス **1-833-613-2262 (フリーダイヤル) (TTY 1-844-214-2471)** までお電話ください。

英語が母国語でない方には、 サポート致します。こちらにお電話下さい **1-833-613-2262 (フリーダイヤル) (TTY 1-844-214-2471)** 。資料に関する情報をご自分の言語で請求することができます。また、通訳サービスによる質問対応が可能です。