



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, visit [www.anglehealth.com](http://www.anglehealth.com) or call (855) 937-1855. 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 [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call (855) 937-1855 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                         | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|---------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$4,000 per individual / \$8,000 per family for <a href="#">network providers</a> ; \$8,000 per individual / \$16,000 per family for <a href="#">out-of-network providers</a> . | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay.<br><br>If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of deductible expenses paid by all family members meets the overall family <a href="#">deductible</a> .                                                                                                                                                                                                    |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. <a href="#">Preventive care</a> is covered before you meet your <a href="#">deductible</a> .                                                                               | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without cost sharing and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-carebenefits">https://www.healthcare.gov/coverage/preventive-carebenefits</a>                                                                            |
| Are there other <a href="#">deductibles</a> for specific services?              | No. There are no other specific <a href="#">deductibles</a> .                                                                                                                   | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | For <a href="#">network providers</a> \$7,000 individual / \$14,000 family; for <a href="#">out-of-network providers</a> \$14,000 individual / \$28,000 family.                 | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limit</a> until the overall family <a href="#">out-of-pocket limit</a> has been met                                                                                                                                                                                                                                                                                                                                              |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">balance billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.                                                    | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="http://www.anglehealth.com">www.anglehealth.com</a> or call (855) 937-1855 for a list of network providers.                                                   | This plan uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's</a> network. You will pay the most if you use an out-of-network <a href="#">provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No                                                                                                                                                                              | You can see the <a href="#">specialist</a> 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<br>(You will pay the least)                                           | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                        |
| If you visit a health care <a href="#">provider's</a> office or clinic                                                                                                                                 | Primary care visit to treat an injury or illness       | 20% coinsurance after deductible                                                       | 50% coinsurance after deductible                   | Coverage is limited to one visit per year for some services. You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. |
|                                                                                                                                                                                                        | <a href="#">Specialist</a> visit                       | 20% coinsurance after deductible                                                       | 50% coinsurance after deductible                   |                                                                                                                                                                                                                                                        |
|                                                                                                                                                                                                        | <a href="#">Preventive care/screening/immunization</a> | No charge                                                                              | Not covered                                        |                                                                                                                                                                                                                                                        |
| If you have a test                                                                                                                                                                                     | <a href="#">Diagnostic test</a> (x-ray, blood work)    | 20% coinsurance after deductible                                                       | 50% coinsurance after deductible                   | <a href="#">Preauthorization</a> may be required for certain services except in the case of an emergency. Please refer to the Certificate of Coverage for details.                                                                                     |
|                                                                                                                                                                                                        | Imaging (CT/PET scans, MRIs)                           | 20% coinsurance after deductible                                                       | 50% coinsurance after deductible                   |                                                                                                                                                                                                                                                        |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.anglehealth.com">www.anglehealth.com</a> | Generic drugs                                          | 20% coinsurance after deductible retail<br>20% coinsurance after deductible mail order | Not covered retail<br>Not covered mail order       | Covers up to a 31-day supply (retail prescription);<br>Covers up to a 90-day supply (mail order prescription).                                                                                                                                         |
|                                                                                                                                                                                                        | Preferred brand drugs                                  | 20% coinsurance after deductible retail<br>20% coinsurance after deductible mail order | Not covered retail<br>Not covered mail order       |                                                                                                                                                                                                                                                        |
|                                                                                                                                                                                                        | Non-preferred brand drugs                              | 20% coinsurance after deductible retail<br>20% coinsurance after deductible mail order | Not covered retail<br>Not covered mail order       |                                                                                                                                                                                                                                                        |
|                                                                                                                                                                                                        | <a href="#">Specialty drugs</a>                        | 20% coinsurance after deductible retail                                                | Not covered retail                                 |                                                                                                                                                                                                                                                        |

|                                                                                  |                                                  |                                  |                                  |                                                                                                                                                                                                                                                                                                                                                             |
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| <b>If you have outpatient surgery</b>                                            | Facility fee (e.g., ambulatory surgery center)   | 20% coinsurance after deductible | 50% coinsurance after deductible | <a href="#">Preauthorization</a> may be required for certain services. Please refer to the Certificate of Coverage for details.                                                                                                                                                                                                                             |
|                                                                                  | Physician/surgeon fees                           | 20% coinsurance after deductible | 50% coinsurance after deductible | <a href="#">Preauthorization</a> may be required for certain services. Please refer to the Certificate of Coverage for details.                                                                                                                                                                                                                             |
| <b>If you need immediate medical attention</b>                                   | <a href="#">Emergency room care</a>              | 20% coinsurance after deductible | 20% coinsurance after deductible |                                                                                                                                                                                                                                                                                                                                                             |
|                                                                                  | <a href="#">Emergency medical transportation</a> | 20% coinsurance after deductible | 20% coinsurance after deductible | <a href="#">Preauthorization</a> may be required for non-emergency transportation.                                                                                                                                                                                                                                                                          |
|                                                                                  | <a href="#">Urgent care</a>                      | 20% coinsurance after deductible | 50% coinsurance after deductible |                                                                                                                                                                                                                                                                                                                                                             |
| <b>If you have a hospital stay</b>                                               | Facility fee (e.g., hospital room)               | 20% coinsurance after deductible | 50% coinsurance after deductible | <a href="#">Preauthorization</a> may be required except in the case of an emergency.                                                                                                                                                                                                                                                                        |
|                                                                                  | Physician/surgeon fees                           | 20% coinsurance after deductible | 50% coinsurance after deductible | <a href="#">Preauthorization</a> may be required except in the case of an emergency.                                                                                                                                                                                                                                                                        |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                              | 20% coinsurance after deductible | 50% coinsurance after deductible | <a href="#">Preauthorization</a> may be required except in the case of an emergency.                                                                                                                                                                                                                                                                        |
|                                                                                  | Inpatient services                               | 20% coinsurance after deductible | 50% coinsurance after deductible |                                                                                                                                                                                                                                                                                                                                                             |
| <b>If you are pregnant</b>                                                       | Office visits                                    | 20% coinsurance after deductible | 50% coinsurance after deductible | Covers 48-hour hospital stay for uncomplicated vaginal delivery and 96-hour hospital stay for uncomplicated caesarean section. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e ultrasound). |
|                                                                                  | Childbirth/delivery professional services        | 20% coinsurance after deductible | 50% coinsurance after deductible |                                                                                                                                                                                                                                                                                                                                                             |
|                                                                                  | Childbirth/delivery facility services            | 20% coinsurance after deductible | 50% coinsurance after deductible |                                                                                                                                                                                                                                                                                                                                                             |

|                                                                       |                                           |                                  |                                  |                                                                                                                                                                                                                           |
|-----------------------------------------------------------------------|-------------------------------------------|----------------------------------|----------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>If you need help recovering or have other special health needs</b> | <a href="#">Home health care</a>          | 20% coinsurance after deductible | 50% coinsurance after deductible | <a href="#">Preauthorization</a> may be required. Coverage limited to 100 days per calendar year.                                                                                                                         |
|                                                                       | <a href="#">Rehabilitation services</a>   | 20% coinsurance after deductible | 50% coinsurance after deductible | Coverage limits per calendar year: Physical, Occupational, and Speech Therapy: 20 visits each for Outpatient therapies. Preauthorization may be required. Up to 40 days per plan year, combined, for Inpatient therapies. |
|                                                                       | <a href="#">Habilitation services</a>     | 20% coinsurance after deductible | 50% coinsurance after deductible | Coverage limits are combined with Rehabilitation services above.                                                                                                                                                          |
|                                                                       | <a href="#">Skilled nursing care</a>      | 20% coinsurance after deductible | 50% coinsurance after deductible | <a href="#">Preauthorization</a> may be required.                                                                                                                                                                         |
|                                                                       | <a href="#">Durable medical equipment</a> | 20% coinsurance after deductible | 50% coinsurance after deductible | <a href="#">Preauthorization</a> may be required for certain services. Please refer to the Certificate of Coverage for details.                                                                                           |
|                                                                       | <a href="#">Hospice services</a>          | 20% coinsurance after deductible | 50% coinsurance after deductible |                                                                                                                                                                                                                           |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam                       | Not covered                      | Not covered                      |                                                                                                                                                                                                                           |
|                                                                       | Children's glasses                        | Not covered                      | Not covered                      |                                                                                                                                                                                                                           |
|                                                                       | Children's dental check-up                | Not covered                      | Not covered                      |                                                                                                                                                                                                                           |

#### Excluded Services & Other Covered Services:

| Services Your Plan Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)                                                                                                                    |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (Adult and Child)</li> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Private duty-nursing</li> <li>• Routine foot care</li> <li>• Vision care (Adult)</li> <li>• Weight Loss Programs</li> </ul> |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.) |
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- Acupuncture
- Bariatric surgery
- Chiropractic Care
- Non-emergency care when traveling outside the U.S.

**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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform); or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov); or contact the [Plan](#). 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](http://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: Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or [dol.gov/ebsa/healthreform](http://dol.gov/ebsa/healthreform); you may also contact the Utah Insurance Department, Office of Consumer Assistance, Suite 3110, State Office Building, Salt Lake City, Utah 84114. To contact Member Services, please call (855) 937-1855, or visit us at [anglehealth.com](http://anglehealth.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? 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](#).

**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.

## 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<br>(9 months of in-network pre-natal care and a hospital delivery)                                                                                                                                                                                                                                                          |                 | Managing Joe's Type 2 Diabetes<br>(a year of routine in-network care of a well- controlled condition)                                                                                                                                                                                                                  |                | Mia's Simple Fracture<br>(in-network emergency room visit and follow up care)                                                                                                                                                                                                                                              |                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
| The <a href="#">plans</a> overall <a href="#">deductible</a>                                                                                                                                                                                                                                                                                     | \$4,000         | The <a href="#">plans</a> overall <a href="#">deductible</a>                                                                                                                                                                                                                                                           | \$4,000        | The <a href="#">plans</a> overall <a href="#">deductible</a>                                                                                                                                                                                                                                                               | \$4,000        |
| <a href="#">Specialist coinsurance</a>                                                                                                                                                                                                                                                                                                           | 20.00%          | <a href="#">Specialist coinsurance</a>                                                                                                                                                                                                                                                                                 | 20.00%         | <a href="#">Specialist coinsurance</a>                                                                                                                                                                                                                                                                                     | 20.00%         |
| Hospital (facility) <a href="#">coinsurance</a>                                                                                                                                                                                                                                                                                                  | 20.00%          | Hospital (facility) <a href="#">coinsurance</a>                                                                                                                                                                                                                                                                        | 20.00%         | Hospital (facility) <a href="#">coinsurance</a>                                                                                                                                                                                                                                                                            | 20.00%         |
| Other <a href="#">coinsurance</a>                                                                                                                                                                                                                                                                                                                | 20.00%          | Other <a href="#">coinsurance</a>                                                                                                                                                                                                                                                                                      | 20.00%         | Other <a href="#">coinsurance</a>                                                                                                                                                                                                                                                                                          | 20.00%         |
| This <b>EXAMPLE</b> event includes services like:<br><a href="#">Specialist</a> office visits ( <i>prenatal care</i> )<br>Childbirth/Delivery Professional Services<br>Childbirth/Delivery Facility Services<br><a href="#">Diagnostic tests</a> ( <i>ultrasounds and blood work</i> )<br><a href="#">Specialist</a> visit ( <i>anesthesia</i> ) |                 | This <b>EXAMPLE</b> event includes services like:<br><a href="#">Primary care physician</a> office visits ( <i>including disease education</i> )<br><a href="#">Diagnostic tests</a> ( <i>blood work</i> )<br><a href="#">Prescription drugs</a><br><a href="#">Durable medical equipment</a> ( <i>glucose meter</i> ) |                | This <b>EXAMPLE</b> event includes services like:<br><a href="#">Emergency room care</a> ( <i>including medical supplies</i> )<br><a href="#">Diagnostic test</a> ( <i>x-ray</i> )<br><a href="#">Durable medical equipment</a> ( <i>crutches</i> )<br><a href="#">Rehabilitation services</a> ( <i>physical therapy</i> ) |                |
| <b>Total Example Cost</b>                                                                                                                                                                                                                                                                                                                        | <b>\$12,700</b> | <b>Total Example Cost</b>                                                                                                                                                                                                                                                                                              | <b>\$5,600</b> | <b>Total Example Cost</b>                                                                                                                                                                                                                                                                                                  | <b>\$2,800</b> |
| In this example, Peg would pay:                                                                                                                                                                                                                                                                                                                  |                 | In this example, Joe would pay:                                                                                                                                                                                                                                                                                        |                | In this example, Mia would pay:                                                                                                                                                                                                                                                                                            |                |
| <i>Cost Sharing</i>                                                                                                                                                                                                                                                                                                                              |                 | <i>Cost Sharing</i>                                                                                                                                                                                                                                                                                                    |                | <i>Cost Sharing</i>                                                                                                                                                                                                                                                                                                        |                |
| <a href="#">Deductibles</a>                                                                                                                                                                                                                                                                                                                      | \$4,000         | <a href="#">Deductibles</a>                                                                                                                                                                                                                                                                                            | \$4,000        | <a href="#">Deductibles</a>                                                                                                                                                                                                                                                                                                | \$2,257        |
| <a href="#">Copayments</a>                                                                                                                                                                                                                                                                                                                       | \$0             | <a href="#">Copayments</a>                                                                                                                                                                                                                                                                                             | \$0            | <a href="#">Copayments</a>                                                                                                                                                                                                                                                                                                 | \$0            |
| <a href="#">Coinsurance</a>                                                                                                                                                                                                                                                                                                                      | \$1,715         | <a href="#">Coinsurance</a>                                                                                                                                                                                                                                                                                            | \$284          | <a href="#">Coinsurance</a>                                                                                                                                                                                                                                                                                                | \$0            |
| <i>What isn't Covered</i>                                                                                                                                                                                                                                                                                                                        |                 | <i>What isn't Covered</i>                                                                                                                                                                                                                                                                                              |                | <i>What isn't Covered</i>                                                                                                                                                                                                                                                                                                  |                |
| Limits or exclusions                                                                                                                                                                                                                                                                                                                             | \$60            | Limits or exclusions                                                                                                                                                                                                                                                                                                   | \$20           | Limits or exclusions                                                                                                                                                                                                                                                                                                       | \$0            |
| <b>The total Peg would pay is</b>                                                                                                                                                                                                                                                                                                                | <b>\$5,775</b>  | <b>The total Joe would pay is</b>                                                                                                                                                                                                                                                                                      | <b>\$4,304</b> | <b>The total Mia would pay is</b>                                                                                                                                                                                                                                                                                          | <b>\$2,257</b> |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Nondiscrimination Notice

Discrimination is Against the Law. Angle Insurance Company of Utah does not exclude people or treat them differently on the basis of race, color, national origin, age, disability or sex in its health programs or activities.

Angle Insurance Company of Utah provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (audio, accessible electronic formats, large prints). The administrator also provides free 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, you can call the Member Services number on the back of your ID card or email careteam@anglehealth.com. If you are hearing impaired call 855-200-0571. If you believe that Angle Insurance Company of Utah has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you have the right to file a grievance by mail PO BOX 21428, Eagan, MN 55121, fax 855-938-4540, or email ag@anglehealth.com.

You also have the right to file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by mail: U.S. Department of Health and Human Services 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; phone: 1-800-368-1019, 800-537-7697 (TTY); or electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Language Access Services

Spanish

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a 855- 200-0571.

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言 援助服務。請致電 855-200-0571.

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 855-200-0571.

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 855- 200-0571.. 번으로 전화해 주십시오.

Navajo

Díí baa akó nínízin: Díí saad bee yáníłtí'go Diné Bizaad, saad bee áká'ánída'áwo'dęę́ę́', t'áá jik'eh, éí ná hól'ę́, kóíí' hódíílnih 855-200-0571.

Nepali

यान िदनुहोस : तपाइर्लेनेपाली बो नु छ भनेतपाइर्को िन त भाषा सहायता सेवाह िन:शुक पमा उपल ध छ । 855-200-0571. मा फोन गनुहोस ।

Tongan

FAKATOKANGA'I: Kapau 'oku ke lea fakatonga, ko e kau fakatonu lea te nau tokoni atu ta'etotongi, pea te ke lava 'o ma'u ia. Telefoni ki he 855-200-0571.

Serb-Croatian

ОБАВЕШТЕЊЕ: Ако говорите српски језик, услуге језичке помоћи доступне су вам бесплатно. Позовите 855-200-0571.

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 855-200-0571.

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 855-200-0571.

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги переводчика. Позвоните 855-200-0571.

Arabic

دعاسملا تامدخ نإف ،ةبیرعلا ثدحتت تنك اذا :ةظوحلم ةكرشب لصتا 0571–200–855 نأجملاب كل رفاوتت ةيوغلاا ..

Mon-khmer, Cambodian

សំគាល់៖ បើសិនអ្នកនិយាយខ្មែរ ឬស្ទើរជិតនិយាយអង់គ្លេស អ្នកអាចស្នើសុំសេវាបកប្រែឥតគិតថ្លៃបាន។ សូមទូរស័ព្ទមក 855-200- 0571.

French

ATTENTION : si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Contactez 855-200-0571.

Japanese

注意事項：日本語を話される場合、無料の言語 支援をご利用いただけます。855-200-0571。 まで ☎ ANGLE-UT NDN 07/21 お電話にてご連絡ください

\* For more information about limitations and exceptions, see the plan or policy document at [www.anglehealth.com](http://www.anglehealth.com).Page 7 of 7