2022 Open Enrollment Oct. 27 – Nov. 17th

SCHOOL CORPORATION EMPLOYEE COMMUNICATION

The 2022 Open Enrollment period for medical insurance will begin on Wednesday, October 27, 2021, and will end on Wednesday, November 17, 2021. Open Enrollment communications including carrier information and summaries will be posted on the State of Indiana's school specific website at http://www.in.gov/spd/2871.htm.

For specific information regarding when you will see the 2022 deductions on your paycheck, please consult your school's benefit coordinator.

IMPORTANT DATES

All changes and additions must be turned in to your school's benefit coordinator **before the end of the day on November 17th**. Changes and additions will be effective January 1, 2022.

- **Non-Tobacco Use Agreement (NTUA):** If you wish to participate in the NTUA for 2022, you must complete and return the enclosed Non-Tobacco Use Agreement to your school's benefit coordinator by November 17, 2021.
    - **Participants who fail to complete and return the NTUA by the deadline will not be eligible for the premium reduction in 2022.**

- **2022 Open Enrollment Changes:** If you wish to make changes to your health plan elections for 2022, you must complete and return the enclosed State of Indiana HealthCare Plan Enrollment Form to your school's benefit coordinator by November 17, 2021.
    - If you are eligible for the 2022 Wellness Premium Discount, your 2022 medical premium will automatically be reduced.

BENEFIT HIGHLIGHTS FOR 2022

What is staying the same

- Three medical plans to choose from
- Wellness discount remains the same
- Tobacco discount remains the same
- All three plans will have prescription drug plans through CVS Caremark

What is changing for 2022

- New Tiered network for medical
- Health Savings Account limits increasing
- Prescription 90-day retail plan changes
- The Employee Assistance Program (EAP) is being discontinued

MEDICAL

Your medical networks for 2022 will look a little different from what you have today. Now is the time to educate yourself on these changes so you can make an informed decision on what plan is the right fit for you and your family.

The State continues to offer three plans: Consumer Driven Health Plan 1, Consumer Driven Health Plan 2, and Traditional Plan. Each plan covers the same services and providers. The difference between each plan is:

- Premium (cost you pay to have the coverage)
- Deductible (amount you must pay, prior to the plan paying)
- Co-Insurance (percentage you pay once your deductible has been met)
- Out-of-pocket maximum (the most you would need to pay prior to the plan paying 100% of the cost).

New for 2022, is the creation of a tiered network. Under each plan, you may choose to use any of the network options. Each network has a diverse group of providers that provide all types of services including preventive care, acute care for illnesses, and chronic care. The big difference between the networks is the cost to you.

Tier 1 - HealthSync: Lowest Cost Option
To save the most money, use providers within the Tier 1 - HealthSync network. This Tier has lower visit cost plus the lowest deductible, out-of-pocket maximum, and co-insurance.

Tier 2 - In-Network
Tier 2 is your next best option. This Tier includes all other In-Network providers. In-Network providers have a contract with Anthem to provide services at a discount. They cannot bill members above that discounted rate.

Out-of-Network: Highest Cost Option
Out-of-Network Providers do not have an agreement with Anthem. Providers can charge you any amount for their services. The health plan will only cover the same cost as an In-Network provider, and you will be balanced billed for any cost exceeding that amount.

You can use providers from all Tiers at any time during the plan year. The amount you pay for each visit depends on the provider you chose for that visit. Each claim is applied to the deductible and out-of-pocket maximums of all Tiers.

To view a full list of HealthSync Providers please vision www.anthem.com/healthSyncProviderFinder/. Step by Step instruction for how to search Anthem's website to find your provider's Tier can be found at https://www.in.gov/spd/openenrollment/files/Anthem-Provider-Search-Guide.pdf.

Below is a quick overview of each plan.

	CDHP 1			CDHP 2			Traditional		
	Tier 1 – HealthSync	Tier 2 – In-Network	Out of Network	Tier 1 – HealthSync	Tier 2 – In-Network	Out of Network	Tier 1 – HealthSync	Tier 2 – In-Network	Out of Network
Deductible									
Single	$2,000	$2,500	$2,500	$1,400	$1,750	$1,750	$750	$1,000	$1,000
Family	$4,000	$5,000	$5,000	$2,800	$3,500	$3,500	$1,500	$2,000	$2,000
Out-of-Pocket Maximum									
Single	$3,500	$4,000	$4,000	$2,500	$3,000	$3,000	$2,000	$2,500	$2,500
Family	$7,000	$8,000	$8,000	$5,000	$6,000	$6,000	$4,000	$5,000	$5,000
Coinsurance Rates									
Office Visit	10%	30%	50%	10%	30%	50%	10%	30%	50%
Inpatient	10%	30%	50%	10%	30%	50%	10%	30%	50%
Emergency Room	10%	10%	10%	10%	10%	10%	10%	10%	10%
Urgent Care	10%	30%	50%	10%	30%	50%	10%	30%	50%
Wellness Prevention	0%	0%	50%	0%	0%	50%	0%	0%	50%

PRESCRIPTION

All three of the medical plans have prescription coverage through CVS Caremark. The three medical plans have the same copay/coinsurance amounts and a large network of pharmacies. For a full list of in-network pharmacies, please visit www.caremark.com.

In-network pharmacies are Tier 1 providers. Prescriptions filled at In-network pharmacies are considered Tier 1 expenses and will count toward both your Tier 1 and Tier 2 deductible and out-of-pocket maximum. 90-day fills at participating retail pharmacies are changing. You can now choose 90-day fills at more pharmacies, but the co-pay and co-insurance is a little higher than past years. Here is a look at the prescription drug plan.

	Prescription Drug Coverage Deductible must be met before coinsurance rates apply		
	Retail Pharmacy Network (Up to 30-day supply)	Mail Order Pharmacy (Up to 90-day supply)	Retail Pharmacy Network (Up to 90-day supply)
Preventive Medicines (mandated by the ACA)	$0 (no deductible)	$0 (no deductible)	$0 (no deductible)
Generic Medicines	$10 copay	$20 copay	$30 copay
Preferred Brand-Name Medicines	20% Min $30. Max $50	20% Min $60, Max $100	20% Min $90, Max $150
Non-Preferred Brand-Name Medicines	40% Min $50, Max $70	40% Min $100, Max $140	40% Min $150, Max $210
Specialty Medicines	40% Min $75, Max $150 (30-day supply)		

NON-TOBACCO USE INCENTIVE AND REQUEST FOR PREMIUM REDUCTION

The state will continue to offer an opportunity for you to save $75.83 in medical premiums per month by agreeing to not use tobacco during the 2022 plan year. To be eligible, you must be tobacco-free by January 1, 2022, and continue to be tobacco free through the calendar year.

In order to receive the premium reduction, you must accept the Non-Tobacco Use Agreement during the Open Enrollment time period. By selecting the "I accept" on the Non-Tobacco Agreement form, you are agreeing to not use any tobacco products throughout 2022 and understand that you may be subject to cotinine testing and agree to such testing. **A positive test result creates a rebuttable presumption of tobacco use and breach of the agreement.**

Only proof of use of an FDA approved Nicotine Replacement Therapy product will be accepted as evidence to rebut the presumption of tobacco use that constitutes a breach of the Non-Tobacco Use Agreement. FDA approved medications for smoking cessation can be found at https://www.fda.gov/consumers/consumer-updates/want-quit-smoking-fda-approved-products-can-help. Vaping and e-cigarette products are not legitimate, FDA approved nicotine replacement therapy products. If you use cessation aids, please keep all of your receipts for these products to demonstrate your compliance with the Agreement.

If you are interested in getting help to become tobacco free, there are resources available to help you. ActiveHealth and Quit Now Indiana all offer free services. To get started please log onto or call:

ActiveHealth
www.myactivehealth.com/StateofIndiana

Quit Now Indiana
www.quitnowindiana.com
1-800-QUIT-NOW (1-800-784-8669)

The Non-Tobacco Use Agreement must be completed each year. If you would like to participate in 2022, you must complete and return the enclosed Non-Tobacco Use Agreement to your school's benefit coordinator by Wednesday, November 17, 2021. Participants who fail to complete and return the form by the deadline will not be eligible for the reduction in premium. Notice: If your physician determines abstaining from the use of tobacco is not medically appropriate, a reasonable alternative standard will be made available for the incentive.

If you accept the Non-Tobacco Use Agreement during Open Enrollment and later find you are unable to keep that pledge, it is your responsibility to notify your school's benefit coordinator and report your change in status. If you are randomly tested and test positive for nicotine during the year, the full insurance premiums will apply, and you will be subject to any other penalty deemed appropriate under the circumstance. This consequence will occur whether your use is self-identified or determined by the State.

DUAL COVERAGE

Dual coverage of the same individual is not allowed under the state's medical plans. For example, if both you and your spouse are eligible for the state health plans (or one is a current employee and the other is a retiree), you may not cover each other on both plans or have the same children on family coverage. This also applies to parents of children who are not married to each other. You may each elect a single plan, one may carry family and the other may waive coverage, or one may carry family with the children and the other carry single coverage.

A second example occurs when an employee who has retired from one area of state employment or a participating school and begins active work in another eligible position or with another employer. In this instance, you have the choice to continue your retiree coverage and waive your active employee coverage, or vice versa. However, you are not permitted to carry state retiree insurance and active state employee coverage simultaneously.

MAXIMUM CONTRIBUTIONS TO A HEALTH SAVINGS ACCOUNT

Contributions are allowed up to the maximum statutory limit. The maximum annual contribution for 2022 is $3,650 for self-only policies and $7,300 for family policies. Individuals age 55 and over may make an additional catch-up contribution of up to $1,000 in 2022. Combined household contributions cannot exceed the family limit of $7,300.

MEDICARE, MEDICAID AND HIP DISQUALIFY YOU FROM HAVING A HEATH SAVINGS ACCOUNT (HSA)

The IRS established Health Savings Accounts (HSAs) as a method to provide individuals a tax advantage to offset their health care costs. In doing so, the IRS created eligibility criteria to qualify for the account. Enrolling in Medicare, Medicaid or HIP disqualifies you from having contributions into an HSA. Once enrolled in any of these plans, you may not receive or make any contributions into an HSA.

Although you can no longer make contributions to your HSA once you are covered by Medicare, Medicaid or HIP, the money accumulated in your HSA from past years remains yours to spend, tax-free, on eligible expenses, including Medicare copays or deductibles, vision expenses and dental expenses. If you are age 65 or over, you also have the option to withdraw the money for any purpose and pay only the income tax without penalty. The same rules also apply if you receive Social Security disability benefits and are enrolled in Medicare.

Please review the below information carefully as it relates to your eligibility to qualify for an HSA.

Medicare

If you elect to receive Social Security Benefits, you are automatically enrolled in Medicare Part A when you turn age 65. If you wish to participate in a Health Savings Account (HSA), you should decline to receive Social Security retirement benefits and waive Medicare Part A. Keep in mind there are potential consequences if you choose to decline or postpone your enrollment. Additionally, if you decided not to take Medicare when you first qualify, please be advised that your Medicare Part A start date may backdate up to six months when you apply for Social Security benefits. Please carefully research all of your options before making your decision.

You can use funds in your HSA to pay for incurred eligible medical expenses for your dependents (as defined by federal regulations), even if they are not covered under your medical plan, or have other coverage, such as Medicare. However, keep in mind that if your spouse is on Medicare, she/he is not eligible to contribute to an HSA in her/his name, regardless of whether or not she/he is covered on your medical plan.

Medicaid and HIP

According to IRS regulations, an individual who is enrolled in Medicaid or HIP is not eligible to make or receive contributions to an HSA. There are tax consequences to both the individual and the employer, if the employer is also contributing to an HSA for the employee. Similar to Medicare, if your dependent(s) is/are covered by Medicaid or HIP but you are not, you may continue to receive contributions to your HSA. Eligibility is based on the subscriber/account holder.

DEPENDENT ELIGIBILITY

Dependents of eligible employees may be covered under the state's medical plans. Please see the below definition of a dependent.

(1) "Dependent" means:

(a) Spouse of an employee;

(b) Any children, step-children, foster children, legally adopted children of the employee or spouse, or children who reside in the employee's home for whom the employee or spouse has been appointed legal guardian or awarded legal custody by a court, under the age of twenty-six (26). Such child shall remain a "dependent" for the entire calendar month during which he or she attains age twenty-six (26). In the event a child:

i.) was defined as a "dependent", prior to age 19, and

ii.) meets the following disability criteria, prior to age 19:

(I) is incapable of self-sustaining employment by reason of mental or physical disability,

(II) resides with the employee at least six (6) months of the year,

and

(III) receives 50% of his or her financial support from the parent

Such child's eligibility for coverage shall continue, if satisfactory evidence of such disability and dependency is received by the State or its third party administrator in accordance with disabled dependent certification and recertification procedures. Eligibility for coverage of the "Dependent" will continue until the employee discontinues his coverage or the disability criteria is no longer met. A Dependent child of the employee who attained age 19 while covered under another Health Care policy and met the disability criteria specified above, is an eligible Dependent for enrollment so long as no break in Coverage longer than sixty-three (63) days has occurred immediately prior to enrollment. Proof of disability and prior coverage will be required. The plan requires periodic documentation from a physician after the child's attainment of the limiting age.

When completing your Open Enrollment, please make sure you carefully review your dependents. If a dependent becomes ineligible for coverage during the year, you must notify your school's benefit coordinator within thirty days of the dependent becoming ineligible. The State will recover on any claims paid for ineligible dependents covered under the plan.

Please Note: If you have questions or concerns about dependent coverage, or wish to enroll a dependent on your plans during Open Enrollment who is over age 26 and meets the definition of a disabled dependent but was not certified last year, call Anthem. Upon your request, you will be mailed an Application for Continuation of Coverage. This form must be completed and returned to Anthem within 30 days of the issue date. **To be eligible to enroll your dependent(s) as part of your Open Enrollment event for an effective date of January 1, 2022, you must contact Anthem during Open Enrollment and Anthem must certify that your dependent(s) meets the definition of a disabled dependent.**

ANTHEM HEALTH AND WELLNESS PROGRAMS

The state is committed to providing health plan members with helpful tools in order to achieve a more active and healthy population. All members enrolled in an Anthem plan receive special services in conjunction with the Anthem Health and Wellness Programs.

Anthem Health and Wellness Programs provides you with support to help you achieve your health goals. Through Anthem's online tool, you have access to resource materials to learn more about health topics and manage any ongoing health issues such as Diabetes, COPD, Cancer, Pregnancy, Tobacco Use and Weight Management to name a few. To start using the online tools, please go to www.anthem.com log in to your account, place your curser on the "My Health Dashboard" tab on the top of the page, and click programs.

In addition to the online tools, representatives from the Anthem may contact you directly as part of one of the Health and Wellness programs. These programs include:

- **Case Management**: Licensed health care professionals work with you and your treating providers as needed to develop a Care Management plan to help meet your needs. Case Management is designed to help members optimize their health care benefits.
- **ConditionCare**: With the guidance of a dedicated nurse team and health professionals you will gain a better understanding of your health, receive help in following your doctor care plan, and learn how to better manage your health.
- **Future Moms**: Provides moms-to-be with telephone access to nurses to discuss pregnancy-related concerns. This program provides the education and tools to help track the pregnancy week-by-week and prepare for the baby.

For more information about these programs please contact Anthem toll-free at 877-814-9709.

ANTHEM HEALTH GUIDE

Did you know that when you call Anthem customer service you will be connected to an Anthem Health Guide. Health Guides can be reached by phone, mobile app, email or even online chat via mobile device or computer. Health Guides work closely with health care professionals, like nurses, health coaches and social workers, to provide personalized and consultative support. A Health Guide can help you:

- Connect with the right benefits and programs for your health care needs including any of the Condition Care programs.
- Stay on top of your follow-up and preventive care with reminders and appointment-scheduling support.
- Compare costs for health care services and find in-network doctors.
- Answer questions about your claims and covered services.

SYDNEY HEALTH

Another great tool is the Sydney Health app. Sydney Health is your own personal health assistant and benefits guide all rolled into one. To start simply download the app.

Log in using your Anthem User Name and Password from their web portal or register as a new user. With the Sydney app you can:

- Find care and check costs
- View claims

- View and use digital ID cards
- See all your benefits including your deductible, co-insurance and out of pocket maximum
- Use the interactive chat feature to get answers quickly
- Sync with your fitness tracker
- Check My Family Health Records (myFHR)

NURSELINE

For those times you are not sure if you need to seek medical care or what level of care is needed, Anthem's NurseLine is available for you. The NurseLine provides anytime, toll-free access to nurses for answers to general health questions and guidance with health concerns. A nurse can help you understand your symptoms or explain medical treatments. Every caller receives credible, reliable information from a registered nurse.

With the help of NurseLine you can lower your health care costs by finding the appropriate level of care that you may need. Members who use NurseLine are 50% less likely to go to the ER for non-emergency cases. If non-emergency care is received in the ER when a more appropriate setting is available, that claim may be reviewed by a medical director using the prudent layperson standard and potentially denied. However, if you are advised by the NurseLine to seek treatment at the ER and it is later determined that the visit was for a non-emergent visit, Anthem will approve the visit.

In addition, the NurseLine can also be used to learn more about specific health topics. More than 300 health topics have been prerecorded and are available in both English and Spanish. These recording are available 24/7 by phone. To access NurseLine, please call 800-337-4770.

LIVEHEALTH ONLINE

Through LiveHealth Online, you have access to in-network, board-certified doctors 24 hours per day, 7 days per week, 365 days per year. The only thing you need is a computer or mobile device with internet access and a camera.

Doctors on LiveHealth Online are available to diagnose and treat a wide variety of medical care needs. Some common items include the flu, a cold, sinus infection, pink eye, rashes, and fever. When appropriate, the doctor can even prescribe medicine and send the prescription to the pharmacy of your choice. **The average cost of a doctor visit using LiveHealth Online is $59.**

Not only can you be seen by a medical doctor, but you can also receive behavioral health services through LiveHealth Online.

Sign up for LiveHealth Online today by visiting www.livehealthonline.com or downloading the mobile app from your app store.

NEW MEMBERSHIP ID CARDS

All State of Indiana health plan participants will receive a new ID card in the mail for the 2022 plan year. Each family member will receive their own unique card prior to January 1st with his or her name. As in the past, the cards will be used for medical, prescription, dental and vision.

Please continue to use your current card for any health or prescription services received before January 1, 2022. Beginning January 1st please present your new ID card to your provider or pharmacy.

EMERGENCY ROOM VISITS

Did you know that more than 65% of all emergency room (ER) visits are not for life-threatening illnesses or injuries but for non-emergency medical concerns that could be treated at a doctor's office or urgent care center? Seeking treatment outside of the ER, will save you both money and time. Below is a quick look at the cost difference between alternative treatment facilities.

Care Facility	Cost
ER	$1,636
Retail Health Clinic	$70
Walk-In Doctor's Office	$105
Urgent Care Center	$147
LiveHealth Online	$59

Non-emergency services are not covered when treated in an emergency room (ER), if more appropriate settings are available. ER claims are reviewed by Anthem using the prudent layperson standard and potentially denied. If your claim is denied, you will be solely responsible for the ER charges. Please note, that non-emergency visits to the ER will be covered if:

- Directed to the emergency room by another medical provider
- Services were provided to a child under the age 14
- There isn't an urgent care or retail clinic within 15 miles
- Visit occurs on a Sunday or major holiday

As a reminder, Anthem's NurseLine is available 24/7 for those times you are not sure where you should seek medical care. If you are advised by the NurseLine to seek treatment at the ER and it is later determined that the visit was for a non-emergent visit, Anthem will approve the visit. To access NurseLine, please call 800-337-4770.

QUALIFYING EVENTS/ MAKING CHANGES AFTER OPEN ENROLLMENT

After Wednesday, November 17th you are not able to make further changes to your benefits. This means you must be certain you elect the coverage that is right for you and add all eligible dependents you wish to. After Open Enrollment, you can only make changes in conjunction with a qualifying event.

Qualifying events are regulated and defined by the IRS. Examples include:

- Changes in your legal marital status (marriage, divorce, separation, annulment or death of spouse).
- Changes in the number of dependents (birth, adoption, placement for adoption or death).
- Changes in employment status for you or your spouse, such as termination of or change in employment, a strike or lockout, or the start or end of an unpaid leave of absence.
- Changes in dependent eligibility status (such as attainment of limiting age).

If you do not report a qualifying event and complete any necessary paperwork within 30 calendar days from the date of the qualifying event, you are not able to add dependents until the next Open Enrollment period. Please note that an ex-spouse is ineligible for coverage as of the day of divorce. It is important that you report ineligible dependents even if it is beyond the 30 day period to minimize recovery of claims.

CHECK LIST FOR A SUCCESSFUL OPEN ENROLLMENT PERIOD

Is your current plan still the right plan for you? Now is the perfect time to review all the options, take a look at your family's current health and finances, and actively identify the plan option(s) that best meets your needs.

To make the election process easier, several resources are available to help you estimate your 2022 expenses, compare plans, and become a more informed consumer. Use this checklist to help guide you through the steps to a successful Open Enrollment:

- ✓ Educate yourself about changes occurring January 1, 2022.
- ✓ Review your plan options.
- ✓ Review your eligible dependents. Please note: children are eligible for coverage until the last day of the month in which they turn 26 years old. If you are making changes for 2022, please be sure to check "Add Dependents" or "Remove Dependents" on the application.
- ✓ Evaluate your HSA contributions, if applicable. Do you need to increase your contributions?
- ✓ Accept or Decline the Non-Tobacco Use Agreement for 2022.
- ✓ **Submit your application and Non-Tobacco Use Agreement to your school's benefit coordinator by November 17, 2021.**

HAVE QUESTIONS? NEED MORE HELP?

For 2022 plan summaries changes, and other Open Enrollment information, please log on to http://www.in.gov/spd/2871.htm.

You may also attend a virtual information session hosted by a representative of the Indiana State Personnel Department's Benefits Division. The one-hour session will be an overview of your 2022 medical/prescription options. Questions are welcomed and will be answered at the end of the presentation.

- Tuesday, October 26th, 4 to 5 p.m. (EDT), Click to join Microsoft Teams meeting

If you have questions about Open Enrollment not answered on the State Personnel Department's Website, contact the insurance carriers or call the Benefits Division at: 317-232-1167 (Indianapolis area) or toll free at 1-877-248-0007 (outside Indianapolis). You may also email BenefitingSchools@spd.in.gov.

AFFORDABLE CARE ACT (ACA) – SECTION 6055

In accordance with Section 6055 of the Internal Revenue Code under the Affordable Care Act (ACA), the state is required to file health coverage information to the IRS by completing an information return along with furnishing statements to individuals who are or have been employed by the state during the year. The IRS will use the information gathered to determine if the employee was in compliance with the individual shared responsibility provision in section 5000A.

In order to file the health coverage information with the IRS, each subscriber and dependent's name and social security number must match the information listed on their social security card. It is your responsibility to ensure that Anthem has the correct information for you and all of your dependents. If it is identified that Anthem has an incorrect name or social security number on file, you will be required to provide documentation to State Personnel Benefits to correct your record.

Please note: if you do not provide your dependent's social security number the IRS may be unable to match the information you provide on your tax return. This may result in receiving an inquiry from the IRS or being liable for a shared responsibility payment.

For more information please visit www.in.gov/spd/2951.htm or contact Indiana State Personnel Benefits at 317-232-1167 or toll-free at 877-248-0007 (if outside of Indianapolis).

CREDITABLE COVERAGE DISCLOSURE NOTICE

If you are Medicare-eligible, there are two important things you need to know about your current coverage and Medicare's prescription drug coverage. First, Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan (Medicare Part D) or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare.

Second, it has been determined that the prescription drug coverage offered as a part of the State of Indiana employee health plans is on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

If you are considering joining Medicare's prescription drug coverage, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. For more information about Medicare's prescription drug coverage please visit: www.medicare.gov.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

1. All stages of reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter. If you would like more information on WHCRA benefits, contact Anthem at 1-877-814-9709.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTICE REGARDING MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health InsuranceMarketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877- KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determinedeligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2021. Contact your State for more information on eligibility –

ALABAMA Medicaid	CALIFORNIA Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov

ALASKA Medicaid	COLORADO Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
The AK Health Insurance Premium Payment ProgramWebsite: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center:1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS Medicaid	**FLORIDA Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA Medicaid	**MASSACHUSETTS Medicaid and CHIP**
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131	Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840
INDIANA Medicaid	**MINNESOTA Medicaid**
Healthy Indiana Plan for low-income adults 19-64Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA Medicaid and CHIP (Hawki)	**MISSOURI Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a- to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS Medicaid	**MONTANA Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KENTUCKY Medicaid	**NEBRASKA Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

LOUISIANA Medicaid	NEVADA Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE Medicaid	**NEW HAMPSHIRE Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext5218
NEW JERSEY Medicaid and CHIP	**SOUTH DAKOTA Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.htmlCHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK Medicaid	**TEXAS Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA Medicaid	**UTAH Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA Medicaid	**VERMONT Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA Medicaid and CHIP	**VIRGINIA Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON Medicaid	**WASHINGTON Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA Medicaid	**WEST VIRGINIA Medicaid**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

RHODE ISLAND Medicaid and CHIP	WISCONSIN Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA Medicaid	**WYOMING Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2021, or for more information onspecial enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Departmentnotes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee BenefitsSecurity Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS

If You are declining enrollment for yourself or Your Dependents (including Your Spouse) because of other health insurance coverage, You may in the future be able to enroll yourself or Your Dependents in this Plan, if You or Your Dependents lose eligibility for that other coverage (or if the Employer stops contributing towards You or Your Dependents' other coverage). However, you must request enrollment within 31 days after you or Your Dependents' other coverage ends (or after the Employer stops contributing toward the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and Your Dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligible Employees and Dependents may also enroll under two additional circumstances:

- the Employee's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated because of loss of eligibility; or
- the Employee or Dependent becomes eligible for a subsidy (state premium assistance program)

The Employee or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

To request special enrollment or obtain more information, contact Anthem toll free at 1-877-814-9709.

NOTICE REGARDING WELLNESS PROGRAM

Indiana's wellness program & non-tobacco use incentives are voluntary and available to all individuals enrolled in the State health insurance plans. The programs are administered according to federal rules permitting employer-sponsored wellness programs that seek to improve participants health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

If you choose to participate in the wellness program you will be encouraged to complete:

- a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease); and
- a biometric screening, which will include a blood test for total cholesterol, HDL, LDL, triglycerides, and fasting blood glucose.

You are not required to complete the HRA or to participate in the blood test or other medical examinations. However, employees who choose to participate in the wellness program may receive incentives.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you the wellness program services, such as goal setting, educational activities, fitness recommendations, or health coaching. You also are encouraged to share your results or concerns with your own doctor.

Additional incentives (such as a $35 bi-weekly premium discount) may be available for plan participants who participate in certain health-related activities (e.g., enter into the Non-Tobacco Use Agreement).

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the Benefits Hotline: SPDBenefits@spd.in.gov or 877-248-0007.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and the State of Indiana may use aggregate information it collects to design a program based on identified health risks in the workplace, the wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individuals who will receive your personally identifiable health information are registered/licensed health care providers (in order to provide you with services), or as necessary for plan administration.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be protected, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, or complaints about the wellness program, please contact the Benefits Hotline: SPDBenefits@spd.in.gov or 877-248-0007.

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn’t in your health plan’s network.

“Out-of-network” describes providers and facilities that haven’t signed a contract with your health plan or it’s third-party administrator (Anthem Blue Cross Blue Shield). Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is

called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Out-of-network cost-shares (i.e., copayments, deductibles and/or coinsurance) will apply to your claim if the treating out-of-network provider determines you are stable, meaning you have been provided necessary emergency care such that your condition will not materially worsen and the out-of-network provider determines: (i) that you are able to travel to a network facility by non-emergency transport; (ii) the out-of-network provider complies with the notice and consent requirement; and (iii) you are in condition to receive the information and provide informed consent. If you continue to receive services from the out-of-network provider after you are stabilized, you will be responsible for the out-of-network cost-shares, and the out-of-network provider will also be able to charge you any difference between the maximum allowable amount and the out-of-network provider's billed charges. This notice and consent exception do not apply if the covered services furnished by an out-of-network provider result from unforeseen and urgent medical needs arising at the time of service.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

Out-of-Network Services Provided at a Network Facility

When you receive covered services from an out-of-network provider at a network facility, your claims will be paid at the out-of-network benefit level if the out-of-network provider gives you proper notice of its charges, and you give written consent to such charges. This means you will be responsible for out-of-network cost-shares for those services and the out-of-network provider can also charge you any difference between the maximum allowable amount and the out-of-network provider's billed charges. This requirement does not apply to ancillary services. Ancillary services are one of the following services: (i) emergency services; (ii

anesthesiology; (iii) pathology; (iv) radiology; (v) neonatology; (vi) diagnostic services; (vii) assistant surgeons; (viii) Hospitalists; (ix) Intensivists; and (x) any services set out by the U.S. Department of Health & Human Services. In addition, Anthem Blue Cross Blue Shield will not apply this notice and consent process to you if Anthem Blue Cross Blue Shield does not have a network provider in your area who can perform the services you require.

Out-of-network providers satisfy the notice and consent requirement as follows: (i) by obtaining your written consent not later than 72 hours prior to the delivery of services; or (ii) if the notice and consent is given on the date of the service, if you make an appointment within 72 hours of the services being delivered.

Anthem Blue Cross Blue Shield is required to confirm the list of network providers in its provider directory every 90 days. If you can show that you received inaccurate information from Anthem Blue Cross Blue Shield that a provider was in-network on a particular claim, then you will be liable for in-network cost shares (i.e., copayments, deductibles, and/or coinsurance) for that claim. Your network cost-shares will be calculated based upon the maximum allowed amount. In addition to your network cost-shares, the out-of-network provider can also charge you for the difference between the maximum allowed amount and their billed charges if the out-of-network provider has complied with balance billing laws.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact Anthem Member Services at the phone number on the back of Your Identification Card or the United States Department of Labor (USDOL).

Visit www.anthem.com for more information about your rights under federal and state laws.

DISCRIMINATION IS AGAINST THE LAW

State of Indiana Employee Health Plans comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. State of Indiana Employee Health Plans do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

State of Indiana Employee Health Plans:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact State Personnel, Employee Relations Division.

If you believe that the State of Indiana Employee Health Plans have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: State Personnel Department, Employee Relations Division, 402 W. Washington St, Room W161, Indianapolis, IN 46204, 1-855-773-4647, V/TTY 1-317-232-4555, Fax 317-232-3089, Email EmployeeRelations@spd.in.gov. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the State Personnel Employee Relations Division 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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-248-0007 (TTY: 1-317-232-4555).

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 1-877-248-0007（TTY：1-317-232-4555）。

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-248-0007 (TTY: 1-317-232-4555).

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-877-248-0007 (TTY: 1-317-232-4555).

သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။

ဖုန်းနံပါတ် 1-877-248-0007 (TTY: 1-317-232-4555) သို့ ခေါ်ဆိုပါ။

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-248-0007 (رقم هاتف الصم والبكم: 1-317-232-4555).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-248-0007 (TTY: 1-317-232-4555)번으로 전화해 주십시오.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-248-0007 (TTY: 1-317-232-4555).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-248-0007 (ATS : 1-317-232-4555).

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。1-877-248-0007（TTY:1-317-232-4555）まで、お電話にてご連絡ください。

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-877-248-0007 (TTY: 1-317-232-4555).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-248-0007 (TTY: 1-317-232-4555).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-248-0007 (телетайп: 1-317-232-4555).

ਧਿਆਨ ਧਿਓ: ਜੇ ਤੁਸੀਂ ਪੰ ਜਾਬੀ ਬੋਲਿ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਧਵਿੱ ਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਿ ਹੈ। 1-877-248-0007 (TTY: 1-317-232-4555) 'ਤੇ ਕਾਲ ਕਰੋ।

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-248-0007 (TTY: 1-317-232-4555) पर कॉल करें।