



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately.**

**This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1 (800) 235-7111 or visit us at [www.qualchoice.com](http://www.qualchoice.com). 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.cciio.cms.gov](http://www.cciio.cms.gov) or call 1 (800) 235-7111 to request a copy.

| Important Questions                                                       | Answers                                                                                                                                                                                                                  | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall <u>deductible</u>?</b>                             | Calendar year <u>deductible</u><br>In Network: Individual \$2,000/Family \$4,000                                                                                                                                         | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .                                                                                                                                                              |
| <b>Are there services covered before you meet your <u>deductible</u>?</b> | Yes. <u>Preventive care</u> , <u>prescription drugs</u> , and physician office visits are not subject to <u>deductible</u>                                                                                               | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain preventive services without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                         |
| <b>Are there other <u>deductibles</u> for specific services?</b>          | No.                                                                                                                                                                                                                      | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>       | In Network: Individual \$3,500/Family \$7,000                                                                                                                                                                            | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.                                                                                                                                                                                                                                                                                    |
| <b>What is not included in the <u>out-of-pocket limit</u>?</b>            | <u>Premium</u> , balance-billed charges (unless <u>balanced billing</u> is prohibited), and health care this <u>plan</u> doesn't cover.                                                                                  | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Will you pay less if you use a <u>network provider</u>?</b>            | Yes. See <a href="https://provider-search.qualchoice.com/default.aspx?n=1&amp;q=1">https://provider-search.qualchoice.com/default.aspx?n=1&amp;q=1</a> or call 1 (800) 235-7111 for a list of <u>network providers</u> . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| <b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>          | Yes.                                                                                                                                                                                                                     | This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .                                                                                                                                                                                                                                                                                                                                                                             |

 All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

| Common Medical Event                                                                                                                                                                        | Services You May Need                            | What You Will Pay                                                         |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|---------------------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                             |                                                  | Network Provider<br>(You will pay the least)                              | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                        |
| If you visit a health care <u>provider's</u> office or clinic                                                                                                                               | Primary care visit to treat an injury or illness | \$25 <u>Copayment</u> / visit<br><u>Deductible</u> does not apply         | Not Covered                                        | 30% <u>coinsurance</u> after deductible for other services and procedures provided in the office other than the consultation                                                                           |
|                                                                                                                                                                                             | <u>Specialist</u> visit                          | \$50 <u>Copayment</u> / visit<br><u>Deductible</u> does not apply         | Not Covered                                        | 30% <u>coinsurance</u> after deductible for other services and procedures provided in the office other than the consultation                                                                           |
|                                                                                                                                                                                             | <u>Preventive care/screening/immunization</u>    | No Cost to you<br><u>Deductible</u> does not apply                        | Not Covered                                        | You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.                      |
| If you have a test                                                                                                                                                                          | <u>Diagnostic test</u> (x-ray, blood work)       | 30% <u>Coinsurance</u> after deductible                                   | Not Covered                                        | None                                                                                                                                                                                                   |
|                                                                                                                                                                                             | Imaging (CT/PET scans, MRIs)                     | 30% <u>Coinsurance</u> after deductible                                   | Not Covered                                        | Requires <u>pre-authorization</u>                                                                                                                                                                      |
| If you need drugs to treat your illness or condition<br>More information about <u>prescription drug coverage</u> is available at <a href="http://www.qualchoice.com">www.qualchoice.com</a> | Generic drugs                                    | \$10 <u>Copayment</u> / prescription<br><u>Deductible</u> does not apply  | Not Covered                                        | Covers up to a 30-day supply (retail prescription)<br><br><u>Pre-authorization/step-therapy</u> may apply<br><br>Maximum quantity per <u>claim</u> may apply<br><br>Your <u>formulary</u> is Essential |
|                                                                                                                                                                                             | Preferred brand drugs                            | \$35 <u>Copayment</u> / prescription<br><u>Deductible</u> does not apply  | Not Covered                                        |                                                                                                                                                                                                        |
|                                                                                                                                                                                             | Non-preferred brand drugs                        | \$65 <u>Copayment</u> / prescription<br><u>Deductible</u> does not apply  | Not Covered                                        |                                                                                                                                                                                                        |
|                                                                                                                                                                                             | <u>Specialty drugs</u>                           | \$200 <u>Copayment</u> / prescription<br><u>Deductible</u> does not apply | Not Covered                                        |                                                                                                                                                                                                        |
| If you have outpatient                                                                                                                                                                      | Facility fee (e.g., ambulatory)                  | 30% <u>Coinsurance</u> after                                              | Not Covered                                        | None                                                                                                                                                                                                   |

| 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)                 |                                                                                             |
| surgery                                                                   | surgery center)                           | deductible                                                                                          |                                                                    |                                                                                             |
|                                                                           | Physician/surgeon fees                    | 30% <u>Coinurance</u> after deductible                                                              | Not Covered                                                        | None                                                                                        |
| If you need immediate medical attention                                   | <u>Emergency room care</u>                | \$100 <u>Copayment</u> / visit<br><u>Deductible</u> does not apply                                  | \$100 <u>Copayment</u> / visit<br><u>Deductible</u> does not apply | None                                                                                        |
|                                                                           | <u>Emergency medical transportation</u>   | 30% <u>Coinurance</u> after deductible                                                              | 30% <u>Coinurance</u> after deductible                             | Coverage is limited to \$1,000/trip for ground ambulance and \$5,000/trip for air ambulance |
|                                                                           | <u>Urgent care</u>                        | \$60 <u>Copayment</u> / visit<br><u>Deductible</u> does not apply                                   | Not Covered                                                        | None                                                                                        |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)        | 30% <u>Coinurance</u> after deductible                                                              | Not Covered                                                        | Requires <u>pre-authorization</u>                                                           |
|                                                                           | Physician/surgeon fees                    | 30% <u>Coinurance</u> after deductible                                                              | Not Covered                                                        | None                                                                                        |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | \$50 <u>Copayment</u> / visit and 30% <u>Coinurance</u> after deductible/ other outpatient services | Not Covered                                                        | <u>Deductible</u> does not apply to office visit                                            |
|                                                                           | Inpatient services                        | 30% <u>Coinurance</u> after deductible                                                              | Not Covered                                                        | Requires <u>pre-authorization</u>                                                           |
| If you are pregnant                                                       | Office visits                             | \$50 <u>Copayment</u> / visit<br><u>Deductible</u> does not apply                                   | Not Covered                                                        | None                                                                                        |
|                                                                           | Childbirth/delivery professional services | 30% <u>Coinurance</u> after deductible                                                              | Not Covered                                                        | None                                                                                        |
|                                                                           | Childbirth/delivery facility services     | 30% <u>Coinurance</u> after deductible                                                              | Not Covered                                                        | Requires <u>pre-authorization</u>                                                           |
| If you need help recovering or have other special health needs            | <u>Home health care</u>                   | 30% <u>Coinurance</u> after deductible                                                              | Not Covered                                                        | Requires <u>pre-authorization</u> , Coverage is limited to 50 visits per calendar year      |
|                                                                           | <u>Rehabilitation services</u>            | \$50 <u>Copayment</u> / visit<br><u>Deductible</u> does not apply                                   | Not Covered                                                        | Coverage is limited to 30 visits per calendar year for PT/OT/ST combined with Chiropractic  |

| 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) |                                                                                                                                                        |
|                                        | <u>Habilitation services</u>     | \$50 <u>Copayment</u> / visit<br><u>Deductible</u> does not apply | Not Covered                                        | Requires <u>pre-authorization</u> , Coverage is limited to 30 visits per calendar year for PT/OT/ST combined with Chiropractic                         |
|                                        | <u>Skilled nursing care</u>      | 30% <u>Coinsurance</u> after deductible                           | Not Covered                                        | Requires <u>pre-authorization</u> , Coverage is limited to 60 days per calendar year for Inpatient <u>Rehabilitation Services/Skilled Nursing Care</u> |
|                                        | <u>Durable medical equipment</u> | 30% <u>Coinsurance</u> after deductible                           | Not Covered                                        | None                                                                                                                                                   |
|                                        | <u>Hospice services</u>          | 30% <u>Coinsurance</u> after deductible                           | Not Covered                                        | Requires <u>pre-authorization</u>                                                                                                                      |
| If your child needs dental or eye care | Children's eye exam              | \$50 <u>Copayment</u> / visit<br><u>Deductible</u> does not apply | Not Covered                                        | Coverage is limited to 1 exam every 12 months up to age 19                                                                                             |
|                                        | Children's glasses               | 30% <u>Coinsurance</u> after deductible                           | Not Covered                                        | Coverage is limited to 1 pair of standard frames & lenses per calendar year up to age 19                                                               |
|                                        | Children's dental check-up       | Not Covered                                                       | Not Covered                                        | None                                                                                                                                                   |

#### Excluded Services & Other Covered Services:

##### **Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- |                                                                                                                                                         |                                                                                                                                                                                                       |                                                                                                                                                                               |
|---------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric surgery</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> </ul> | <ul style="list-style-type: none"> <li>• Routine eye care (Adult)</li> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine foot care unless related to treatment of diabetes</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 plan document.)**

- |                                                                       |                                                                              |
|-----------------------------------------------------------------------|------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Chiropractic care</li> </ul> | <ul style="list-style-type: none"> <li>• Hearing aids, \$1400/ear</li> </ul> |
|-----------------------------------------------------------------------|------------------------------------------------------------------------------|

**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: Qualchoice phone number 1-800-235-7111; the state insurance department phone number 1-800-852-5494; Department of Labor's Employee Benefits Security Administration 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). 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 to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the state insurance department phone number 1-800-852-5494.

**Does this plan provide Minimum Essential Coverage? Yes.**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet Minimum Value Standards? Yes.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

#### **Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-235-7111.

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

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

|                                          |         |
|------------------------------------------|---------|
| ■ The plan's overall <u>deductible</u>   | \$2,000 |
| ■ <u>Specialist copay</u>                | \$50    |
| ■ Hospital (facility) <u>coinsurance</u> | 30%     |
| ■ Other <u>coinsurance</u>               | 30%     |

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
Diagnostic tests (*ultrasounds and blood work*)  
Specialist visit (*anesthesia*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$2,000        |
| <u>Copayments</u>                 | \$0            |
| <u>Coinsurance</u>                | \$1,500        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$3,560</b> |

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                          |         |
|------------------------------------------|---------|
| ■ The plan's overall <u>deductible</u>   | \$2,000 |
| ■ <u>Specialist copay</u>                | \$50    |
| ■ Hospital (facility) <u>coinsurance</u> | 30%     |
| ■ Other <u>coinsurance</u>               | 30%     |

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
Diagnostic tests (*blood work*)  
Prescription drugs  
Durable medical equipment (*glucose meter*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$7,400</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$2,000        |
| <u>Copayments</u>                 | \$1,400        |
| <u>Coinsurance</u>                | \$60           |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Joe would pay is</b> | <b>\$3,520</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|                                          |         |
|------------------------------------------|---------|
| ■ The plan's overall <u>deductible</u>   | \$2,000 |
| ■ <u>Specialist copay</u>                | \$50    |
| ■ Hospital (facility) <u>coinsurance</u> | 30%     |
| ■ Other <u>coinsurance</u>               | 30%     |

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$1,900</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$1,900        |
| <u>Copayments</u>                 | \$0            |
| <u>Coinsurance</u>                | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,900</b> |

## Non-Discrimination and Accessibility Notice

QualChoice complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. QualChoice does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

QualChoice:

- Provides 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 Customer Service at (501) 228-7111. If you believe that QualChoice has 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:

QualChoice Civil Rights Coordinator  
QualChoice  
P.O. Box 25610  
Little Rock, AR 72221-5610  
(501) 228-7111  
Fax #: 501-707-6729  
QCA\_COE@qualchoice.com

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

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

## Notice of Discrimination Grievance Procedures

It is the policy of QualChoice not to discriminate on the basis of race, color, national origin, prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. 18116) and its implementing regulations at 45 CFR part 92, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of the QualChoice Civil Rights Coordinator, who has been designated

to coordinate the efforts of QualChoice to comply with Section 1557 (the "Section 1557 Coordinator"):

QualChoice Civil Rights Coordinator  
QualChoice  
P.O. Box 25610  
Little Rock, AR 72221-5610  
(501) 228-7111  
Fax #: 501-707-6729  
QCA\_COE@qualchoice.com

Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age or disability may file a grievance under this procedure. It is against the law for QualChoice to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

Procedure:

- Grievances must be submitted to the Section 1557 Coordinator within sixty (60) days of the date the person filing the grievance becomes aware of the alleged discriminatory action.
- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Section 1557 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 1557 Coordinator will maintain the files and records of QualChoice relating to such grievances. To the extent possible, and in accordance with applicable law, the Section 1557 Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.
- The Section 1557 Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, no later than thirty (30) days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies.
- The person filing the grievance may appeal the decision of the Section 1557 Coordinator by writing to the Vice President Corporate Responsibility within fifteen (15) days of receiving the Section 1557 Coordinator's decision. The Vice President Corporate Responsibility shall issue a written decision in response to the appeal no later than thirty (30) days after its filing.

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the U.S. Department



of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201.

Complaint forms are available at: <http://www.hhs.gov/ocr/office/file/index.html>. Such complaints must be filed within 180 days of the date of the alleged discrimination. QualChoice will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Section 1557 Coordinator will be responsible for such arrangements.

**QualChoice offers help for members with limited English proficiency (LEP). The following statement is printed in the top languages used in Arkansas, as required by the Federal government:**

**ATTENTION: Language assistance services, free of charge, are available to you.**  
**Call 1-800-235-7111 (TTY: 711).**

#### Spanish

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-235-7111 (TTY: 711).

#### Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-235-7111 (TTY: 711).

#### Marshallese

LAL: Ñe kwōj kōnōno Kajin M̧ajōl, kwomaroñ bōk jerbal in jipañ ilo kajin ñe aṇ ejjeļok wōṇāān. Kaalok 1-800-235-7111 (TTY: 711).

#### 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 1-800-235-7111 (TTY: 711)。

#### Lao

ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສຍຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-235-7111 (TTY: 711).

#### Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-235-7111 (TTY: 711).

#### Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-235-7111 (رقم هاتف الصم والبكم: 711).

#### German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-235-7111 (TTY: 711).

#### French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-235-7111 (ATS: 711).

#### Hmong

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-235-7111 (TTY: 711).

#### Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-235-7111 (TTY: 711) 번으로 전화해 주십시오.

#### Portuguese

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-235-7111 (TTY: 711).

#### 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。1-800-235-7111 (TTY: 711) まで、お電話にてご連絡ください。

#### Hindi

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-235-7111 (TTY: 711) पर कॉल करें।

#### Gujarati

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-235-7111 (TTY: 711).