Highlights of your Health Care Coverage

UIC (Ukpeagvik Inupiat Corporation)
Group Number: 4002747

Effective Date: 01/01/2026

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.
Medical Benefits apply after the calendar-year deductible is met unless otherwise noted, or if the cost share is a copay.

MEDICAL PLAN	**2026 HP HDHP WITH HRA $2,000/20%/$3,400 - ESSENTIALS**	
	YUKON IN-NETWORK	**OUT-OF-NETWORK**
MEDICAL COST SHARES		
Individual Deductible PCY (Family aggregate deductible 2x Individual)	$2,000 PCY/$4,000 PCY	$4,000 PCY/$8,000 PCY
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	20% Preferred/30% Participating	Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	$3,400 PCY/$6,800 PCY	$6,800 PCY/$13,600 PCY
Office Visit Cost Share	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
Preventive Office Visit (Unlimited, subject to standard medical guidelines)	Covered in Full	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
Immunizations (Unlimited, subject to standard medical guidelines)	Covered in Full	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
Health Education (HE) (Unlimited)	Covered in Full	Covered In Full
Diabetes Health Education (DE) (Unlimited)	Covered in Full	Covered In Full
CHRONIC CONDITION MANAGEMENT PROGRAMS		
Diabetes Management Plus	Included	Included
Diabetes Prevention Plus	Included	Included
Hypertension Plus	Included	Included
Weight Management	Included - Standard	Included - Standard
PROFESSIONAL CARE		
Professional Office Visit (Includes Telemedicine)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
APP-BASED VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	In Network Deductible, then 20% Preferred	Not Covered

MEDICAL PLAN	2026 HP HDHP WITH HRA $2,000/20%/$3,400 - ESSENTIALS	
	YUKON IN-NETWORK	**OUT-OF-NETWORK**
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit	Not Covered
Telemedicine - Outpatient Rehab (Virtual Care Only) (Shared with Rehab Outpatient Care)	Subject to Rehab Outpatient Care In-Network Cost Share	Not Covered
DIAGNOSTIC SERVICES		
Preventive Imaging and Laboratory	Covered in Full	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
Diagnostic Laboratory	In Network Deductible, then 20% Preferred/30% Participating	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
Basic Diagnostic Imaging	In Network Deductible, then 20% Preferred/30% Participating	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
Major Diagnostic Imaging	In Network Deductible, then 20% Preferred/30% Participating	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
Preventive Mammography	Covered in Full	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
Diagnostic Mammography	In Network Deductible, then 0%	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
Supplemental Breast Exam	In Network Deductible, then 0%	Covered as any other service
FACILITY CARE		
Inpatient Facility	In Network Deductible, then 20% Preferred/30% Participating	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
Inpatient Professional Services	In Network Deductible, then 20% Preferred/30% Participating	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
Outpatient Surgery Facility	In Network Deductible, then 20% Preferred/30% Participating	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
Outpatient Facility	In Network Deductible, then 20% Preferred/30% Participating	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
MEDICAL PLAN	**2026 HP HDHP WITH HRA $2,000/20%/$3,400 - ESSENTIALS**	

	YUKON IN-NETWORK	OUT-OF-NETWORK
Skilled Nursing Facility (100 days PCY)	In Network Deductible, then 20% Preferred/30% Participating	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
HOSPICE & HOME HEALTH CARE		
Hospice Inpatient Facility (Inpatient: Unlimited; Respite: 240 hours; 6 month limit)	In Network Deductible, then 20% Preferred/30% Participating	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
Hospice Care (Home Health and Respite) (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	In Network Deductible, then 20% Preferred/30% Participating	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
Home Health Visits (130 visits PCY)	In Network Deductible, then 20% Preferred/30% Participating	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
MATERNITY & REPRODUCTIVE CARE		
Contraceptive Management Services (Unlimited)	Covered in Full	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
Sterilization - Female (Unlimited)	Covered in Full	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
Sterilization - Male (Unlimited)	In Network Deductible, then 20% Preferred/30% Participating	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
MEDICAL CARE COORDINATION AND TRAVEL SERVICES		
Centers of Excellence Packaged Services (Eligible Services Include: Total Joint Replacement (Knee & Hip Replacement), Spine & Gynecology)	In Network Deductible, then 0%	Covered as any other service
Centers of Excellence Travel and Care Coordination (See Elective Procedure Travel)	See Elective Procedure Travel	See Elective Procedure Travel
Medical Access Transportation (3 round trips PCY for patient (includes 3 round trips PCY for parent or guardian if pt. under 19 yrs of age))	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Transplants (Unlimited; $75,000 donor)	Covered as any other service	Not Covered
Transplant Travel & Lodging ($7,500 travel and lodging)	Subject to Deductible, then 0%	Subject to Deductible, then 0%
Elective Procedure Travel (Prior Approval Required: Member & Medically Necessary Companion - Air: 1 round-trip per episode; Surface Transportation & Parking: $35/day; Ferry Transportation $50 per person each way; Lodging $50/day per person)	$2,000 PCY/$4,000 PCY Deductible, then 0%	$2,000 PCY/$4,000 PCY Deductible, then 0%
Medical Services from Elective Procedure Travel	Covered as any other service	Covered as any other service
EMERGENCY CARE		
MEDICAL PLAN	**2026 HP HDHP WITH HRA $2,000/20%/$3,400 - ESSENTIALS**	

	YUKON IN-NETWORK	OUT-OF-NETWORK
Emergency Care	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Emergency Room Physician	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Urgent Care Center	In Network Deductible, then 20% preferred & participating	Same as In-Network
Ambulance Transportation (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Non-Emergent Ground Ambulance (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Air Ambulance (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Non-Emergent Air Ambulance (Unlimited)	In Network Deductible, then 20% Preferred/30% Participating	Out of Network Deductible, then CD & Professional: 40%; ARP
ALTERNATIVE CARE		
Acupuncture (12 visits PCY)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
Manipulations (Spinal and other) (20 visits PCY)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
CHEMICAL DEPENDENCY & MENTAL HEALTH		
Chemical Dependency Inpatient Facility Care (Unlimited)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
Chemical Dependency Outpatient Professional Care (Unlimited)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
Mental Health Inpatient Facility Care (Unlimited)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
Mental Health Outpatient Professional Care (Unlimited)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
PHARMACY		
Formulary Drug List	E4 Essentials Formulary Tier 1 = preferred generic Tier 2 = preferred brand Tier 3 = preferred specialty Tier 4 = non-preferred all drugs	E4 Essentials Formulary Tier 1 = preferred generic Tier 2 = preferred brand Tier 3 = preferred specialty Tier 4 = non-preferred all drugs
Enhanced Preventive Drug List (PV Core Plus (Buy-Up))	Covered in Full	Specialty Drugs: Not Covered; All other Drugs: Same as In-network cost share
MEDICAL PLAN	**2026 HP HDHP WITH HRA $2,000/20%/$3,400 - ESSENTIALS**	

	YUKON IN-NETWORK	OUT-OF-NETWORK
Prescription Drugs - Retail (Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days)	Tier 1 = Subject to Deductible, then $10 Tier 2 = Subject to Deductible, then $30 Tier 3 = Subject to Deductible, then $50 Tier 4 = Subject to Deductible, then 30% (cost shares apply to the OOP Max)	Specialty Drugs: Not Covered; All other Drugs: Same as In-network cost share
Prescription Drugs - Mail (Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days)	Tier 1 = Subject to Deductible, then $25 Tier 2 = Subject to Deductible, then $75 Tier 3 = Subject to Deductible, then $50 Tier 4 = Subject to Deductible, then 30% (cost shares apply to the OOP Max)	Not Covered
REHABILITATION & NEURO		
Rehab Inpatient Facility (100 days PCY)	In Network Deductible, then 20% Preferred/30% Participating	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy; Cardiac & Pulmonary Rehab.; and Chronic Pain (45 visits PCY)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
OTHER SERVICES		
Allergy/Therapeutic Injections	In Network Deductible, then 20% Preferred/30% Participating	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
Medical Supplies, Equipment, Prosthetics (Unlimited)	In Network Deductible, then 20% Preferred/30% Participating	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
SUPPLEMENTAL BENEFITS		
Routine Hearing Exam (1 PCY)	Exam & Test: INN Deductible, then 20% Preferred/30% Partcipating	OON Deductible, then 40%
Hearing Hardware ($800 limit every 3 consecutive years)	In Network Deductible, then 20%	In Network Deductible, then 20%
ANNUAL PLAN MAXIMUM		
Annual Plan Maximum	Unlimited	Unlimited

Benefits provided at 100% of allowable charges; not subject to deductible or coinsurance.
Seasonal immunizations provided at a pharmacy will be covered in full up to maximum allowable amount.
Autism: Mental Health, Psychological & Neuropsychological Testing, Outpatient Professional & Facility Care covered as any other service.

Copays are not subject to the deductible unless otherwise noted.

Prior Authorization is required for many services to be covered. For more information please refer to your benefit booklet.
PCY = Per Calendar Year. Balance billing may apply if a provider is not contracted with Premera Blue Cross Blue Shield of Alaska. Members are responsible for amounts in excess of the allowable charge.

This is not a complete explanation of covered services, exclusions, limitations, reductions or the terms of the plan.This benefit highlight is not a contract and may change. Please see your benefit booklet or call Customer Service for full coverage information including a description of waiting periods, limitations, and exclusions.

Funding Account Setup – For Groups

Employer Information

♦♦♦

Check One:

☐ We are setting up new funding account(s).

☐ We are renewing.
- ☐ and we have **no** account changes.
- ☐ and we need to make changes.
- ☐ Our employer group number is: **4002747**

If you are a renewing employer, please contact your sales representative for a summary document and pre-populated form from the previous year.

Employer's legal name (same name that is used on the health plan): UIC (Ukpeagvik Inupiat Corporation)		Tax ID number: 920044212
Street address: 3800 CENTERPOINT DR STE 502		
City: ANCHORAGE	State: AK	ZIP: 99503
Mailing address (if different than street address):		
Employer type: ☐ Sole Proprietor ☐ LLC ☐ S-Corporation ☐ Other		
Number of eligible employees: 1053	Plan effective date: 01/01/2026	Plan end date: 12/31/2026

You–the employer contact or representative: HOPE DONALDSON		Title:
Phone number: 9076775258	Fax number:	Email address: hope.donaldson@uicalaska.com

Highlights of your Personal Funding Accounts

UIC (Ukpeagvik Inupiat Corporation)
Group Number: 4002747

Effective Date: 01/01/2026

Below is a brief description of the key features of the funding account(s) your employer has chosen to offer.

FUNDING - CDH PLAN	2026 HRA FUNDING PRODUCT
FUNDING ACCOUNT SETUP	
Setup/Renewal	Account Renewal (Facets)
PACKAGED FUNDING OPTIONS	
Funding Options	A La Carte
HEALTH REIMBURSEMENT ARRANGEMENTS (HRA)	
HRA Type	Facets Based HRA
HEALTH REIMBURSEMENT ARRANGEMENTS (HRA) INFORMATION	
Timing of Allocation Funding	Annual
Eligible Expenses	Medical Plan - Deductible, Coinsurance
Aggregate Member pays First Dollar Amount	HRA Pays First
HRA Percent	HRA Pays First
Member Percent	HRA Pays First
Employee Only	HRA Pays First
Employee + 1	HRA Pays First
Employee + Family	HRA Pays First
HRA Allocation Tiers	Aggregate
HRA Rollover Options	No Limits - Entire Balance Rolls Over (Facets)
HRA Rollover Maximum Tier Structure	Not Tiered
Allocation Proration Options	Prorated (Based on Months Left in Plan Year)
HEALTHCARE CLAIMS SUBMISSION	
Debit Card or Streamlined Claims	Streamlined Claims for Payment
Streamlined Claims: Payment Method	Auto-Pay Only
Streamlined Claims: Payee	Payment for medical, dental, and vision made to the Provider Only

Benefits provided at 100% of allowable charges; not subject to deductible or coinsurance.
Seasonal immunizations provided at a pharmacy will be covered in full up to maximum allowable amount.
Autism: Mental Health, Psychological & Neuropsychological Testing, Outpatient Professional & Facility Care covered as any other service.

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Prior Authorization is required for many services to be covered. For more information please refer to your benefit booklet.
PCY = Per Calendar Year. Balance billing may apply if a provider is not contracted with Premera Blue Cross Blue Shield of Alaska. Members are responsible for amounts in excess of the allowable charge.

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HRA Rollover Options	No Limits - Entire Balance Rolls Over (Facets)
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Streamlined Claims: Payment Method	Auto-Pay Only
Streamlined Claims: Payee	Payment for medical, dental, and vision made to the Provider Only

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Highlights of your Dental Coverage

UIC (Ukpeagvik Inupiat Corporation)

Group Number: 4002747

Effective Date: 01/01/2026

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.

DENTAL PLAN	2026 DENTAL	
	IN-NETWORK	**OUT-OF-NETWORK**
Dental Cost Share		
Individual Deductible	$50	Shared with In Network
Family Deductible	$150	Shared with In Network
Preventive Cost Share	Covered in Full	Covered in Full
Basic Cost Share	Deductible, then 20%	Deductible, then 20%
Major Cost Share	Deductible, then 50%	Deductible, then 50%
Dental Reimbursement (Dental Choice Network)	AK fee schedule	80th percentile (in-state) and 90th percentile (out-of-state)
Dental Annual Maximum	$2,500 PCY applies to basic and major services	Shared with In Network
Benefit Enhancement Rider		
Benefit Enhancement Rider	Endodontics & Periodontal Treatment (In Basic)	Endodontics & Periodontal Treatment (In Basic)
Office Visit		
Routine Comprehensive / Periodic Oral Exams (2 PCY)	Covered in Full	Covered in Full
Problem Focused/Emergency Exam (2 PCY)	Covered in Full	Covered in Full
Office Visits, Prof Consults, Perio Evals (2 PCY (Shared with Routine))	Covered in Full	Covered in Full
Preventive Services		
Prophylaxis - Cleaning (2 PCY)	Covered in Full	Covered in Full
Fluoride Treatments (2 PCY; under the age of 20)	Covered in Full	Covered in Full
Sealants (Under age 20 limited to permanent molars only, Replacements limited to once every 24 consecutive months)	Covered in Full	Covered in Full
Space Maintainers (Members under age 20)	Covered in Full	Covered in Full
Diagnostic Imaging		
Bitewings X-rays (Unlimited)	Covered in Full	Covered in Full
Panoramic X-ray or comparable Conebeam view (1 complete series, 1 panoramic or 1 comparable cone beam view in any 36 consecutive months)	Covered in Full	Covered in Full
Restorative		
Fillings (1 per surface every 24 consecutive months)	Deductible, then 20%	Deductible, then 20%

Highlights of your Dental Coverage

UIC (Ukpeagvik Inupiat Corporation)

Group Number: 4002747

Effective Date: 01/01/2026

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.

DENTAL PLAN	2026 DENTAL	
	IN-NETWORK	OUT-OF-NETWORK
Installation of Inlays, Onlays and Crowns (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%
Re-cement or Rebond Crowns/Inlay/Onlay (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 20%
Repair Crown/Inlay/Onlay (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 20%
Endodontics		
Endodontic Therapy - Root Canal (Once per tooth every 24 consecutive months)	Deductible, then 20%	Deductible, then 20%
Periodontics		
Periodontal Maintenance (4 PCY)	Deductible, then 20%	Deductible, then 20%
Full Mouth Debridement (Once every 36 consecutive months)	Deductible, then 20%	Deductible, then 20%
Periodontal Scaling and Root Planing (Once per quadrant every 24 consecutive months)	Deductible, then 20%	Deductible, then 20%
Periodontal Surgery (Once per quadrant every 36 consecutive months)	Deductible, then 20%	Deductible, then 20%
Periodontal Soft Tissue Grafts (Once per quadrant every 36 consecutive months)	Deductible, then 20%	Deductible, then 20%
Prosthodontics (Dentures/Bridges)		
Installation or Replacement of Dentures, Partials and Fixed Bridges (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%
Repair or Re-cement Bridgework and Dentures (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 20%
Implant Services		
Implant Crowns/Bridge/Denture (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%
Oral Surgery		
Simple Extractions (Unlimited)	Deductible, then 20%	Deductible, then 20%
Surgical Extractions (Unlimited)	Deductible, then 20%	Deductible, then 20%
Oral Surgery (Unlimited)	Deductible, then 20%	Deductible, then 20%
General Services		
Anesthesia - Intravenous or General (Unlimited)	Deductible, then 20%	Deductible, then 20%
Anesthesia - Nitrous Oxide (Unlimited)	Deductible, then 20%	Deductible, then 20%

Highlights of your Dental Coverage

UIC (Ukpeagvik Inupiat Corporation)

Group Number: 4002747

Effective Date: 01/01/2026

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.

DENTAL PLAN	2026 DENTAL	
	IN-NETWORK	OUT-OF-NETWORK
Palliative (Emergency) Treatment of Dental Pain (Unlimited)	Deductible, then 20%	Deductible, then 20%
TMJ Rider		
TMJ Rider (Not Covered)	Not Covered	Not Covered

Diagnostic and Preventive Care Services aren't subject to the calendar year deductible. PCY = Per Calendar Year. Balance billing may apply if a provider is not contracted with Premera Blue Cross Blue Shield of Alaska. Members are responsible for amounts in excess of the allowable charge.

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Discrimination is Against the Law

Premera Blue Cross Blue Shield of Alaska (Premera) complies vvith applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people wth disabilities to communicate effectively vvith us, such as qualified sign language interpreters and witten information in other formats (large print, audio, accessible electronic formats, other formats)_ Premera provides free language services to people whose primary language is not English, such as qualified interpreters and information witten in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance wth: Civil Rights Coordinator-Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint wth the US 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: US. Department of Health and Human Services, 200 Independence Ave 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_

Language Assistance

PAUNAWA Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-508-4722 (TTY 711).

ATENCION si habla espafiol, tiene a su disposici6n servicios graluitos de asistencia linguistica. Llame al 800-508-4722 (TTY: 711).

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MO LOU SILAFIA Afai e le tautala Gagana fa'a Samoa, o loo iai auaunaga fesoasoan, e fai fua e leai se lologi, mo oe, Telefoni mai 800-508-4722 (TTY 711).

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Nu saritaem ti llocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 800-508-4722 (TTY 711). CHU Y

NÐu bÐn n6i TiÐng ViÐt. c6 cac d!ch v1,1 h6 trq ng6n ngO, miÐn phi danh cho bÐn GQi s6 800-508-4722 (TTY: 711).

YBArAl flKLl.\0 Bl-1 p03MOBnflETe yKpaYHCbKOfO MOBOfO, Bl-1 MOmeTe 3B8PHYTl-1Cfl AO 6e3KOWTOBHOY cnym61-1 MOBHOY niATPl-1MKl-1.

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Ð.l'W: t71f),t:"W'l:JAmtr1'1'VII'Jf.Jru'i':i1m'J'fl'l-nu1'm'J"liCJm'll!Ðel'Vl1'1il11:n'1Am b'Vl'J' 800-508-4722 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur VerfUgung. Rufnummer: 800-508-4722 (TTY: 711).

UWAGA: Jezeli m6wisz po polsku, mozesz skorzystac z bezptatnej pomocy JÐzykowej. Zadzwon pod numer 800-508-4722 (TTY 711).

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ATANSYON Si w pale Krey6l Ayisyen, gen sevis ed pou lang ki disponib gratis pou ou Rele 800-508-4722 (TTY 711)

ATTENTION : Si vous parlez franc;;ais, des services d'aide linguistique vous sont proposes gratuitement Appelez le 800-508-4722 (ATS : 711)

ATENCAO: Se fala portugues, encontram-se disponiveis servic;;os linguisticos, gratis Ligue para 800-508-4722 (TTY: 711)

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti Chiamare ii numero 800-508-4722 (TTY 711)

..:Y ÐY'w 800-508-4722 (TTY: 711) ½ ..i..&½ cs" t'"i_>! \....,& c5IY. uK.l_) w_J Ð cs'½_:, c:-.., Ð,..i,;:,.s: cs" ÐCS""""J.§ u½_:, Ð _t1 **:4..3..J"**

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