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, contact www.caresource.com/marketplace or call 1-855-202-0622. 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.caresource.com/marketplace or call 1-855-202-0622 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$950 individual/$1,900 family per benefit year	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$1,950 individual/ $3,900 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.caresource.com/marketplace or call 1-855-202-0622 for a list of network providers.	This plan uses a provider network. Services provided by out-of-network providers will not be covered by this plan except in certain limited circumstances (such as emergency care)*. Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

* For more information about limitations and exceptions, see the plan or policy document at www.caresource.com/marketplace or call 1-855-202-0622.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay	Not covered	None
	Specialist visit	$30 copay	Not covered	Plan covers 100% of allowed amount in excess of the copayment. Copayment waived when the only charge is for allergy injections/serum. If you receive services in addition to office visits, additional copayments, deductibles, or coinsurance may apply.
	Other practitioner office visit Nurse practitioner/retail clinic Chiropractor	$10 copay 15% coinsurance after deductible	Not covered	None Manipulation therapy - 30 visits per benefit year**
	Preventive care/screening/immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: $80 copay after deductible Lab: 15% coinsurance after deductible	Not covered	May require prior authorization May require prior authorization
	Imaging (CT/PET scans, MRIs)	$200 copay after deductible	Not covered	May require prior authorization
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caresouce.com/marketplace.	Preventive drugs	Retail: No charge Mail-Order: No charge	Not covered	Retail: Up to a 30-day supply Mail-Order: Up to a 90-day supply Certain drugs may require a prior authorization. You may be required to use a lower cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.
	Generic drugs	Retail: $10 copay Mail-Order: $25 copay	Not covered	
	Preferred brand drugs	Retail: $40 copay Mail-Order: $100 copay	Not covered	

* For more information about limitations and exceptions, see the plan or policy document at www.caresource.com/marketplace or call 1-855-202-0622.
** In addition to any visits covered under chronic pain treatment benefit.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Non-preferred brand drugs	Retail: 15% coinsurance after deductible Mail-Order: 15% coinsurance after deductible	Not covered	Retail: Up to a 30-day supply Mail-Order: Up to a 90-day supply Certain drugs may require a prior authorization. You may be required to use a lower cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.
	Specialty drugs	Retail: 15% coinsurance after deductible Mail-Order: 15% coinsurance after deductible	Not covered	
	Specialty drugs non-preferred	Retail: 50% coinsurance after deductible Mail-Order: 50% coinsurance after deductible	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance after deductible	Not covered	May require prior authorization
	Physician/surgeon fees	15% coinsurance after deductible	Not covered	None
If you need immediate medical attention	Emergency room care	$400 copay after deductible	$400 copay after deductible	Copayment waived if you are admitted to the hospital directly from the Emergency Department.
	Emergency medical transportation	15% coinsurance after deductible	15% coinsurance after deductible	Ambulance transports must be made to the closest local facility that can provide you with covered services appropriate for your medical condition.
	Urgent care	$75 copay	$75 copay	If you receive services in addition to urgent care, additional copayments, deductibles, or coinsurance may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	$400 copay after deductible	Not covered	Prior authorization required
	Physician/surgeon fees	$400 copay after deductible	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information*
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay for office visits and 15% coinsurance after deductible for other outpatient services	Not covered	Prior authorization may be required for all inpatient stays, residential treatment programs, partial hospitalization programs and intensive outpatient services.
	Inpatient services	$400 copay after deductible	Not covered	
If you are pregnant	Office visits	$30 copay	Not covered	Copayment covers initial physician visit and all subsequent prenatal visits, postnatal visits, and physician delivery charges covered under the Global Maternity Fee. Additional copayments, deductibles, or coinsurance may apply depending on services rendered in addition to the Global Maternity Fee. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	$400 copay after deductible	Not covered	
	Childbirth/delivery facility services	$400 copay after deductible	Not covered	Your cost for inpatient services only. See above for physician delivery charges.
If you need help recovering or have other special health needs	Home health care	15% coinsurance after deductible	Not covered	100 visits per benefit year. A visit equals at least 4 hours.
	Chronic pain treatment	$10 copay	Not covered	20 combined visits per event
	Rehabilitation services Physical therapy Occupational therapy Speech therapy Cardiac rehabilitation Chiropractic services	 $10 copay $10 copay 15% coinsurance after deductible 15% coinsurance after deductible 15% coinsurance after deductible	Not covered	 30 visits per benefit year** 30 visits per benefit year** 30 visits per benefit year 36 visits per benefit year Manipulation therapy - 30 visits per benefit year**

* For more information about limitations and exceptions, see the plan or policy document at www.caresource.com/marketplace or call 1-855-202-0622.
** In addition to any visits covered under chronic pain treatment benefit.

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	 Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information*
	Habilitation services Physical therapy Occupational therapy Speech therapy	 $10 copay $10 copay 15% coinsurance after deductible	Not covered	 30 visits per benefit year** 30 visits per benefit year** 30 visits per benefit year
	Skilled nursing care	$400 copay after deductible	Not covered	Any combination of benefits for skilled nursing facility/inpatient rehabilitation services is limited to 90 days per calendar year.
	Private duty nursing	15% coinsurance after deductible	Not covered	35 visits per benefit year. A visit equals 8 hours or less.
	Durable medical equipment	15% coinsurance after deductible	Not covered	May require prior authorization
	Hospice services	15% coinsurance after deductible	Not covered	Prior authorization is required for inpatient, respite or continuous care levels of care.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	1 routine eye exam per benefit year
	Low vision exam	15% coinsurance after deductible	Not covered	May require prior authorization
	Children's glasses	No charge	Not covered	Limited to one pair of glasses or a 12-month supply of contact lenses per benefit year
	Children's dental check-up	No charge	Not covered	2 dental check-ups per benefit year

* For more information about limitations and exceptions, see the plan or policy document at www.caresource.com/marketplace or call 1-855-202-0622.
** In addition to any visits covered under chronic pain treatment benefit.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Abortion (Except in cases of rape, incest, or when the life of the mother is endangered) • Acupuncture	• Cosmetic surgery • Hearing aids • Long term care	• Non-emergency care when traveling outside the U.S. • Routine foot care • Weight loss programs

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

• Bariatric surgery
• Chiropractic care
• Dental care (Adult), if optional Dental + Vision is selected:
  • No charge for preventive services
  • 20% coinsurance for basic and major restorative services
  • $800 limit per benefit year
	• Infertility treatment
	• Private duty nursing
		• Routine eye care (Adult)
		• If optional Dental + Vision is selected:
		  • $250 limit per benefit year for glasses or contacts

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: 1-888-879-9842. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information 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 West Virginia Department of Insurance: 1-888-879-9842.

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

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-855-202-0622.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-202-0622.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-855-202-0622.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-202-0622.

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 prenatal care and a hospital delivery)

The plan's overall deductible	$950
Specialist ***copayment***	$30
Hospital (facility) ***copayment***	$400
Other ***coinsurance***	15%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,840

In this example, Peg would pay:

Cost Sharing	
Deductibles	$950
Copayments	$509
Coinsurance	$491
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,010

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

The plan's overall deductible	$950
Specialist ***copayment***	$30
Hospital (facility) ***copayment***	$400
Other ***coinsurance***	15%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,460

In this example, Joe would pay:

Cost Sharing	
Deductibles	$950
Copayments	$764
Coinsurance	$236
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$2,005

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

The plan's overall deductible	$950
Specialist ***copayment***	$30
Hospital (facility) ***copayment***	$400
Other ***coinsurance***	15%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$2,010

In this example, Mia would pay:

Cost Sharing	
Deductibles	$950
Copayments	$210
Coinsurance	$208
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,368

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

CareSource®

This Notice has Important Information. This notice has important information about your application or coverage through CareSource. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 1-855-202-0622 TTY:711.

ARABIC
يحتوي هذا الإشعار على معلومات مهمة. يحتوي هذا الإشعار على معلومات مهمة بخصوص طلبك أو التغطية التي تحصل عليها من خلال CareSource. ابحث عن التواريخ المهمة في هذا الإشعار. قد تحتاج إلى اتخاذ إجراء معين قبل حلول أحد التواريخ للحفاظ على التغطية الصحية التي تحصل عليها أو للحصول على مساعدة بشأن التكاليف. يحق لك الحصول على مساعدة ومعلومات مجانًا وباللغة التي تتحدث بها. اتصل على 1-855-202-0622 TTY:711.

AMHARIC ይህ ማስታወቂያ አስፈላጊ መረጃ ይዟል። ይህ ማስታወቂያ ስለ ማመልከቻዎ ወይም የ CareSource ሽፋን አስፈላጊ መረጃ አለው። በዚህ ማስታወቂያ ውስጥ ቁልፍ ቀኖችን ፈልጉ። የጤናን ሽፋንዎን ለመጠበቅና በአከፋፈል እርዳታ ለማግኘት በተውሰኑ የጊዜ ገደቦች እርምጃ መውሰድ ይገባዎት ይሆናል። ይህን መረጃ እንዲያገኙ እና ያለምንም ክፍያ በቋንቋዎ እርዳታ እንዲያገኙ መብት አለዎት። 1-855-202-0622 TTY:711 ይደውሉ።

BURMESE ဤအသိပေးစာတွင် အရေးကြီးသော အချက်အလက်များ ပါဝင်ပါသည်။ ဤအသိပေးစာတွင် သင့်လျှောက်ထားမှု သို့မဟုတ် CareSource အတွင်း အကျုံးဝင်မှုအကြောင်း အရေးကြီးသော အချက်အလက်များ ပါဝင်ပါသည်။ ဤအသိပေးစာတွင်း အရေးကြီးသော ရက်စွဲများကို ရှာထားပါ။ သင့်ကျန်းမာရေး အကျုံးဝင်မှုအား ဆက်လက်ထားရှိထားရန် သို့မဟုတ် ကုန်ကျစရိတ်များနှင့် ပတ်သက်ပြီး အကူအညီရရှိရန် အချို့သော နောက်ဆုံးရက် သတ်မှတ်ချက်များဖြင့် ဆောင်ရွက်မှုပြုရန် လိုအပ်နိုင်ပါသည်။ သင်ပြောဆိုသော ဘာသာစကားဖြင့် အကူအညီနှင့် အချက်အလက်များအား အခမဲ့ ရယူနိုင်ရန် အခွင့်အရေးရှိပါသည်။ 1-855-202-0622 TTY:711 ဤတွင် နံပါတ်ဖြည့်သွင်းပါ] သို့ ခေါ်ဆိုပါ။

CHINESE 此通知包含重要信息。 此通知包含关于您的申请以及 CareSource 医疗保险覆盖范围的重要信息。 请仔细查看本通知中的关键日期。 您可能需要在某些标注的截止日期前采取行动，以确保您的健康保险有效或者付费项目获得帮助。您有权免费获得以您的语言提供的此信息和帮助。 请致电 1-855-202-0622 TTY:711。

CUSHITE – OROMO Beeksisni kun odeeffannoo barbaachisaa qaba. Beeksisti kun sagantaa yookan karaa CareSource tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qaba. Guyyaawwan murteessaa ta'an beeksisa kana keessatti ilaalaa. Tarii kaffaltiidhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhumaa irratti wanti raawwattan jiraachuu danda'a. Kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabaattu. Lakkoofsa bilbilaa1-855-202-0622 TTY:711 tii bilbilaa.

DUTCH Deze kennisgeving bevat belangrijke informatie. Deze kennisgeving bevat belangrijke informatie over uw aanvraag of dekking via CareSource. Let op belangrijke data in deze kennisgeving. Het kan nodig zijn om actie te ondernemen vóór bepaalde deadlines om uw gezondheidszorgdekking of hulp met de kosten te behouden. U hebt het recht om deze informatie en hulp kosteloos te ontvangen in uw taal. Bel 1-855-202-0622 TTY:711.

FRENCH (CANADA) Cet avis contient des renseignements importants. Cet avis contient des renseignements importants sur votre demande d'assurance auprès de CareSource ou la couverture obtenue par l'intermédiaire de CareSource. Prenez connaissance des dates clés mentionnées dans le présent avis. Assurez-vous de respecter les délais indiqués pour conserver votre protection et contribuer à réduire les coûts. Vous avez le droit d'obtenir gratuitement ces renseignements et du soutien dans votre langue. Téléphonez au 1-855-202-0622 TTY:711.

GERMAN Dieser Hinweis enthält wichtige Information. Dieser Hinweis enthält wichtige Information über Ihren Antrag oder Ihren Schutz durch CareSource. Achten Sie auf Schlüsseltermine in diesem Hinweis. Sie müssen eventuell innerhalb von bestimmten Fristen Maßnahmen ergreifen, um Ihre Gesundheitsversorgung aufrecht zu erhalten oder Hilfe mit den Kosten zu bekommen. Sie haben das Recht, kostenfrei in Ihrer eigenen Sprache diese Hilfe und Information zu bekommen. Rufen Sie die Nummer 1-855-202-0622 TTY:711an.

GUJARATI આ સૂચના માં અગત્યની માહિતી છે. આ સૂચના માં તમારી અરજી અથવા CareSource દ્વારા કવરેજ વિશે અગત્યની માહિતી છે. આ સૂચના માંની ખાસ તારીખો જુઓ. તમે તમારા આરોગ્ય કવરેજ રાખવા અથવા ખર્ચ સાથે મદદ કરવા માટે અમુક ચોક્કસ મુદતો દ્વારા પગલાં લેવાની જરૂર છે. તમને આ માહિતી અને મદદ તમારી ભાષા માં વિના મૂલ્યે મેળવવાનો અધિકાર છે. આ 1-855-202-0622 TTY:711સંપર્ક કરો.

HINDI इस नोटिस में महत्वपूर्ण सूचना है। इस नोटिस में आपके आवेदन या CareSource के माध्यम से आपके कवरेज के बारे में महत्वपूर्ण जानकारी है। इस नोटिस में मुख्य तारिखों को देखें। आपको लागत सहित अपने हेल्थ कवरेज या सहायता को बनाए रखने के लिए विभिन्न समयसीमाओं में कार्रवाई करने की जरूरत हो सकती है। आपके पास बगैर किसी लागत के अपनी भाषा में यह जानकारी और सहायता प्राप्त करने का अधिकार है। कॉल करें, 1-855-202-0622 TTY:711.

ITALIAN Questa comunicazione contiene informazioni importanti. Questa comunicazione contiene informazioni importanti circa la sua iscrizione o copertura tramite CareSource. Cerchi le date principali in questa comunicazione. Potrebbe dover intraprendere delle azioni entro certe scadenze per mantenere la Sua copertura sanitaria o per contribuire ai costi. Ha il diritto di avere queste informazioni e supporto nella Sua lingua, senza alcun costo. Chiami il 1-855-202-0622 TTY:711.

JAPANESE この通知には重要な情報が含まれています。 この通知には、CareSource の申請または補償範囲に関する重要な情報が含まれています。 この通知に記載されている重要な日付をご確認ください。 健康保険や有料サポートを維持するには、特定の期日までに措置を講じていただく必要があります。 ご希望の言語による情報とサポートが無料で提供されます。 1-855-202-0622 TTY:711 にご連絡ください。

KOREAN 본 통지서는 중요한 정보를 담고 있습니다. CareSource 가입이나 혜택에 대한 중요한 정보가 안내되어 있습니다. 본 통지서에 나와 있는 주요 날짜들을 확인해 주십시오. 의료 혜택을 받거나 비용을 절약하시려면 특정 기한까지 조치를 취하셔야 할 수 있습니다. 원하는 언어로 별도 비용 없이 관련 정보와 안내를 받으실 수 있습니다. 다음 번호로 전화해 주십시오: 1-855-202-0622 TTY:711.

PENNSYLVANIA DUTCH Die Bekanntmaching gebt wichdichi Auskunft. Die Bekanntmaching gebt wichdichi Auskunft baut dei Application oder Coverage mit CareSource. Geb Acht fer wichdiche Daadem in die Bekanntmachung. Es iss meeglich, ass du ebbes duh muscht, an beschtimmde Deadlines, so ass du dei Health Coverage bhalde kannscht, odder bezaahle helfe kannscht. Du hoscht es Recht fer die Information un Hilf in deinre eegne Schprooch griege, un die Hilf koschtet nix. 1-855-202-0622 TTY:711

RUSSIAN Если у Вас или у кого-то, кому Вы помогаете, есть вопросы относительно CareSource, Вы имеете право бесплатно получить помощь и информацию на Вашем языке. Для разговора с переводчиком, позвоните по номеру 1-855-202-0622 TTY:711.

SPANISH Este aviso incluye información importante. Este aviso incluye información importante sobre su solicitud o su cobertura de CareSource. Busque las fechas clave en este aviso. Es probable que deba realizar acciones dentro de determinado plazo para mantener su cobertura médica o recibir ayuda con los costos. Tiene derecho a recibir esta información y ayuda en su propio idioma sin costo. Llame al 1-855-202-0622 TTY:711.

UKRAINIAN Це Повідомлення містить важливу інформацію. Це повідомлення містить важливу інформацію про вашу заяву чи відшкодування через CareSource. Шукайте важливі дати у цьому повідомленні. Вам може знадобитися вжити заходів у певні терміни, щоб отримати медичне страхування чи допомогу з витратами. Ви маєте право на безкоштовне отримання цієї інформації та допомоги вашою мовою. Зателефонуйте за номером 1-855-202-0622 TTY:711.

VIETNAMESE Thông báo này có thông tin quan trọng. Thông báo này có thông tin quan trọng về đơn xin hoặc bảo hiểm của bạn thông qua CareSource. Hãy xem những ngày quan trọng trong thông báo này. Bạn có thể cần phải hành động trước một số thời hạn nhất định để duy trì bảo hiểm sức khỏe của mình hay được trợ giúp có trả phí. Bạn có quyền được nhận thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Vui lòng gọi số 1-855-202-0622 TTY:711.

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CareSource

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CareSource provides free aids and services to people with disabilities to communicate effectively with us, such as: (1) qualified sign language interpreters, and (2) written information in other formats (large print, audio, accessible electronic formats, other formats). In addition, CareSource provides free language services to people whose primary language is not English, such as: (1) qualified interpreters, and (2) information written in other languages. If you need these services, please contact CareSource at 1-855-202-0622 TTY : 711.

If you believe that CareSource has failed to provide the above mentioned services to you or discriminated in another way on the basis of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status, you may file a grievance, with:

CareSource
Attn: Civil Rights Coordinator
P.O. Box 1947, Dayton, Ohio 45401
1-844-539-1732, TTY: 711
Fax: 1-844-417-6254

CivilRightsCoordinator@CareSource.com

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

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office of 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.