ETSELL, INC.

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October 14, 2020

TO: All Employees

FROM: Tracy Sherrill Henderlight

RE: Your Health Coverage Options

This document and all attachments are being provided to inform employees of your health insurance options. For the plan year 12/1/2020 through 11/30/2021 the employer-sponsored health coverage is with Blue Cross Blue Shield of Tennessee (BCBST). The plan summary is attached.

Employee-sponsored coverage is available to all full-time employees who are employees who work a minimum of 30 hours per week for 121 days or more per year. Employees who meet these criteria are eligible to enroll in the medical plan after 30 days of employment. Once enrolled, coverage begins on the 1st day of the month following the 30th day of employment. If enrollment is waived at that time, employees and dependents can enroll during the open enrollment period which is Nov. 1 through Nov. 30 each year.

Etsell, Inc. will pay ½ of the premium toward an employee's INDIVIDUAL monthly MEDICAL premium which equates to $342.07 per month for the new plan year. The employee is responsible to pay the other half of $342.06 per month via payroll tax deduction. This premium does **NOT** reflect charges for dental, vision or any supplemental plans and does **NOT** reflect premiums for dependent coverage. If you choose to enroll in additional plans or wish to cover dependents, those premiums will be paid by the employee at an additional cost. Etsell, Inc. reserves the right to pay an additional portion of premiums depending on length of employment, management positions or other factors.

Etsell, Inc. also offers a Health Savings Account (HSA) option which allows insurance subscribers to make pre-tax contributions to a Health Savings Account that the employee can use toward the medical deductible, copays or certain medical supplies. For the calendar year 2021 employees can contribute to the HSA through tax-free payroll deductions in any amount up to a maximum of $3600 for the year for individuals under the age of 55 / $4600 for individuals over the age of 55. The maximum annual contribution for families is $7200 per year if covered employee is under the age of 55 / $8200 if covered employee is 55 or older. If an employee chooses to contribute to their own HSA, please notify OpCenter immediately upon enrollment for sign-up instructions.

For Medicare-eligible subscribers, the prescription drug coverage available under the company's group medical plan has been reviewed and found to be a creditable plan. Prescription coverage is creditable if the total expected paid claims for Medicare-eligible subscribers will be at least equal under the group plan to the total expected paid claims for the same subscriber under the defined standard prescription drug coverage under Medicare Part D. Each Medicare-eligible subscriber should review their own individual circumstances to determine their need to enroll in Medicare Part D. Additional information regarding Medicare can be found at www.medicare.gov.

Depending on the percentage of income it costs an employee to pay for their portion of the company plan premium, employees also have the option to seek insurance coverage through the Marketplace. The Marketplace will be managed by each state or by the federal government depending on the state the employee resides in. Visit www.Healthcare.gov for more information on eligibility, enrollment, available coverage and premiums available through the Marketplace. If an employee purchases a qualified health plan through the Marketplace, the employee loses the employer contribution to any employer-sponsored health plans.

All individuals are required to have minimum essential coverage, and individuals without the required coverage may pay a penalty assessed via tax return.

Please call Operations Center with any questions regarding the Blue Cross Blue Shield of Tennessee plan offerings or if you have any enrollment or premium questions.

Thank you,
Tracy Sherrill Henderlight
Etsell, Inc.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact _____

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The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
Etsell, Inc.	available upon request
5. Employer address	**6. Employer phone number**
139 Fox Rd, Ste 105	(865) 588-9698

7. City	8. State	9. ZIP code
Knoxville	TN	37922

10. Who can we contact about employee health coverage at this job?	
Joy Reed or Tracy Henderlight	
11. Phone number (if different from above)	**12. Email address**
same	jreed@shrineservices.com

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

Full-time employees who have worked at least 30 days. Employees are considered full-time if they work a minimum of 30 hours per week for at least 121 days per year

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

1) A spouse of a covered employee.
2) Dependent children of a covered employee up the child's age of 26.
* An employee must have coverage on themselves in order to get coverage for dependents.

☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☒ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $342.07
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☒ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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 1-800-565-9140 (TTY: 1-800-848-0299) or visit us at www.bcbst.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 or call 1-800-565-9140 to request a copy. Coverage documents are not available until after the effective date of your coverage, but you may obtain a sample at **http://www.bcbst.com/samplepolicy/2020/LG .** This sample may not match your benefits exactly, so you should review your coverage document once it is available.

Contributions made by you and/or your employer to health savings accounts (HSAs), flexible spending accounts (FSAs), or health reimbursement arrangements (HRAs) may help pay your deductible or other out-of-pocket expenses.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $3,000 person/$6,000 family Out-of-network: $6,000 person/$12,000 family	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. Deductible doesn't apply to 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. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
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?	In-network: $4,000 person/$8,000 family Out-of-network: $12,000 person/$24,000 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?	Premium, balance-billing charges, penalties, 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. This plan uses Network S. See www.bcbst.com/NetSP or call 1-800-565-9140 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). 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.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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	50% coinsurance	50% coinsurance	PhysicianNow - Powered by MDLIVE: 50% coinsurance
	Specialist visit	50% coinsurance	50% coinsurance	None
	Preventive care/screening/ immunization	No charge	50% coinsurance	A1c testing will be covered at 100%. 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. Travel immunization not covered in office or clinic setting.
If you have a test	Diagnostic test (x-ray, blood work)	50% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	50% coinsurance	50% coinsurance	Prior Authorization required. Your cost share may increase to 60% if not obtained.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbst.com/rxp	Generic drugs	50% coinsurance	50% coinsurance	30 day supply for Retail Network; up to 90 day supply for Home Delivery or Plus90 Network. $10/$35/$60 copayment per 30 day supply for generic/preferred brand/non-preferred brand drugs on Preventive Drug List.
	Preferred brand drugs	50% coinsurance	50% coinsurance	30 day supply for Retail Network; up to 90 day supply for Home Delivery or Plus90 Network. $10/$35/$60 copayment per 30 day supply for generic/preferred brand/non-preferred brand drugs on Preventive Drug List.
	Non-preferred brand drugs	50% coinsurance	50% coinsurance	
	Specialty drugs	50% coinsurance	Not Covered	Up to a 30 day supply. Must use a pharmacy in the Preferred Specialty Pharmacy Network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% coinsurance	50% coinsurance	Prior Authorization required for certain outpatient procedures. Your cost share may

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				increase to 60% if not obtained.
	Physician/surgeon fees	50% coinsurance	50% coinsurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 60% if not obtained.
If you need immediate medical attention	Emergency room care	50% coinsurance	50% coinsurance	None
	Emergency medical transportation	50% coinsurance	50% coinsurance	None
	Urgent care	50% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance	50% coinsurance	Prior Authorization required. Your cost share may increase to 60% if not obtained.
	Physician/surgeon fees	50% coinsurance	50% coinsurance	Prior Authorization required. Your cost share may increase to 60% if not obtained.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	50% coinsurance	50% coinsurance	Prior Authorization required for electro-convulsive therapy (ECT). Your cost share may increase to 60% if not obtained.
	Inpatient services	50% coinsurance	50% coinsurance	Prior Authorization required. Your cost share may increase to 60% if not obtained.
If you are pregnant	Office visits	50% coinsurance	50% coinsurance	PhysicianNow - Powered by MDLIVE: 50% coinsurance
	Childbirth/delivery professional services	50% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	50% coinsurance	50% coinsurance	None
If you need help recovering or have other special health needs	Home health care	50% coinsurance	50% coinsurance	Limited to 60 visits per year.
	Rehabilitation services	50% coinsurance	50% coinsurance	Therapy limited to 20 visits per type per year. Cardiac/Pulmonary rehab limited to 36 visits per type per year.
	Habilitation services	50% coinsurance	50% coinsurance	Therapy limited to 20 visits per type per year. Cardiac/Pulmonary rehab limited to 36 visits per type per year.
	Skilled nursing care	50% coinsurance	50% coinsurance	Skilled nursing and rehabilitation facility limited to 60 days combined per year.
	Durable medical equipment	50% coinsurance	50% coinsurance	Prior Authorization may be required for certain durable medical equipment. Your cost share may increase to 60% if not

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				obtained.
	Hospice services	50% coinsurance	50% coinsurance	Prior Authorization required for inpatient hospice. Your cost share may increase to 60% if not obtained.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Hearing aids for adults
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine eye care (Children)
- Routine foot care for non-diabetics
- Weight loss programs

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

- Acupuncture
- Chiropractic care
- Hearing aids for children under 18
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For plans subject to ERISA, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental plans, the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- For church plans, the State Division of Benefits Administration at 1-866-576-0029.
- BlueCross at 1-800-565-9140 or www.bcbst.com, or contact your plan administrator.

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:

- BlueCross at 1-800-565-9140 or www.bcbst.com, or your plan administrator.

- For plans subject to ERISA, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- The State Division of Benefits Administration at 1-866-576-0029.

Additionally, a consumer assistance program can help you file your appeal. Contact the Tennessee Department of Commerce and Insurance (TDCI) at 1-800-342-4029, https://sbs-tn.naic.org/Lion-Web/servlet/org.naic.sbs.ext.onlineComplaint.OnlineComplaintCtrl?spanishVersion=N, or email them at CIS.Complaints@state.tn.us. You may also write them at 500 James Robertson Pkwy, Davy Crockett Tower, 6th Floor, Nashville, TN 37243.

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.

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 deductible	**$3,000**
Specialist coinsurance	**50%**
Hospital (facility) coinsurance	**50%**
Other coinsurance	**50%**

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,060**

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

The plan's overall deductible	**$3,000**
Specialist coinsurance	**50%**
Hospital (facility) coinsurance	**50%**
Other coinsurance	**50%**

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,100
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$50
The total Joe would pay is	**$2,350**

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

The plan's overall deductible	**$3,000**
Specialist coinsurance	**50%**
Hospital (facility) coinsurance	**50%**
Other coinsurance	**50%**

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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

Nondiscrimination Notice

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

BlueCross:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: (1) qualified interpreters and (2) written information in other formats, such as large print, audio and accessible electronic formats.
- Provides free language services to people whose primary language is not English, such as: (1) qualified interpreters and (2) written information in other languages.

If you need these services, contact a consumer advisor at the number on the back of your Member ID card or call 1-800-565-9140 (TTY: 1-800-848-0298 or 711).

If you believe that BlueCross 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 ("Nondiscrimination Grievance"). For help with preparing and submitting your Nondiscrimination Grievance, contact a consumer advisor at the number on the back of your Member ID card or call 1-800-565-9140 (TTY: 1-800-848-0298 or 711). They can provide you with the appropriate form to use in submitting a Nondiscrimination Grievance. You can file a Nondiscrimination Grievance in person or by mail, fax or email. Address your Nondiscrimination Grievance to: Nondiscrimination Compliance Coordinator; c/o Manager, Operations, Member Benefits Administration; 1 Cameron Hill Circle, Suite 0019, Chattanooga, TN 37402-0019; (423) 591-9208 (fax); Nondiscrimination_OfficeGM@bcbst.com (email).

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, 1–800–368–1019, 800–537–7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Language Access Services:

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-565-9140 (TTY: 1-800-848-0298).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-565-9140 (رقم هاتف الصم والبكم: 800-848-0298-1

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 1-800-565-9140 (TTY:1-800-848-0298)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.
Gọi số 1-800-565-9140 (TTY:1-800-848-0298).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-565-9140 (TTY: 1-800-848-0298) 번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-565-9140 (ATS : 1-800-848-0298).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-565-9140 (TTY: 1-800-848-0298).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-565-9140 (መስማት ለተሳናቸው: 1-800-848-0298).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-565-9140 (TTY: 1-800-848-0298).

સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-565-9140 (TTY:1-800-848-0298)

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。1-800-565-9140 (TTY:1-800-848-0298) まで、お電話にてご連絡ください。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-565-9140 (TTY:1-800-848-0298).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-565-9140 (TTY:1-800-848-0298) पर कॉल करें।

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-565-9140 (телетайп: 1-800-848-0298).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-565-9140 (TTY:1-800-848-0298) تماس بگیرید.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou.
Rele 1-800-565-9140 (TTY: 1-800-848-0298).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-565-9140 (TTY: 1-800-848-0298).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-565-9140 (TTY: 1-800-848-0298).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti.Chiamare il numero 1-800-565-9140 (TTY: 1-800-848-0298).

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-565-9140 (TTY: 1-800-848-0298).


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Feel better fast . . .

It's simple. Teladoc provides access to U.S. board-certified physicians who can resolve most non-emergency medical issues via phone or online video.

Talk to a doctor 24/7/365, anywhere

<10 MINUTE
MEDIAN CALL BACK TIME

HOW IT WORKS

STEP 1: CONTACT TELADOC 24/7/365

Access to Teladoc's nationwide network of board-certified physicians is available via phone, video or mobile app.

STEP 2: TALK WITH A PHYSICIAN

A physician will review the patient's medical history and contact them within minutes.

STEP 3: RESOLVE THE ISSUE

A physician will diagnose and prescribe medication, if medically necessary, electronically to the pharmacy of choice.

TELADOC PHYSICIANS ARE:

U.S. board-certified in internal medicine, family practice, emergency medicine or pediatrics • State-licensed • U.S. residents who average 20 years of experience.

. . . with proven results . . .

With Teladoc, it costs less to feel better. Teladoc significantly lowers costs and improves access to care by providing an alternative to urgent care or ER usage.

Delivering a member experience that delights

95% SATISFACTION

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INDEPENDENT STUDY BY VERACITY ANALYTICS

Dr. Niteesh Choudhry of Harvard Medical School concludes:

"Teladoc resolves patient issues faster with increased savings, by redirecting care from ER and office visits."

- Dr. Niteesh Choudhry

AVERAGE COST PER EPISODE*

ER Visit
$2,661

Office Visit
$191

$673 **Average claims savings per episode of care**

+

$44 **Average productivity savings**

=

$717 Total savings per consult

*Episode of care: Includes initial encounter and any subsequent utilization of follow-up office visits, hospitalization, or ER utilization, resulting from initial encounter within a 30-day window for same and related diagnoses.

Data is from research from Niteesh Choudhry of Veracity Analytics, using claims data from the nation's largest home improvement retailer.

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Teladoc is a convenient alternative to urgent care or ER visits. U.S. board-certified physicians are available anytime, anywhere, and can resolve many non-emergency medical issues.

DIAGNOSE, TREAT AND PRESCRIBE

Teladoc physicians can prescribe medication, when medically necessary for a wide range of conditions.*

SOME CONDITIONS WE TREAT INCLUDE

GENERAL HEALTH

Talk to a doctor within minutes.

- Cold & Flu symptoms
- Bronchitis
- Allergies
- Pink eye
- Urinary tract infections
- Respiratory infections
- Sinus problems
- Ear infections

And more!

DERMATOLOGY

A specialist at your fingertips.

- Skin Infections
- Acne
- Skin rash
- Abrasions
- Moles/Warts

And more!

BEHAVIORAL HEALTH

Counseling on your terms.

- Stress/Anxiety
- Depression
- Addiction
- Domestic abuse
- Grief counselling

And more!

* Teladoc physicians do not prescribe substances controlled by the DEA, non-therapeutic, and/or certain other drugs which may be harmful because of potential for abuse.