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, [https://eoc.anthem.com/eocdps/aso](https://eoc.anthem.com/eocdps/aso). 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.healthcare.gov/sbc-glossary/](https://www.healthcare.gov/sbc-glossary/) or call (844) 422-7714 to request a copy.

### Important Questions

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>$125/individual or $250/family for In-Network Providers, $250/individual or $500/family for Out-of-Network Providers.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. Preventive care, Primary Care visit, Specialist visit, and Vision exam for In-Network Providers.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>No.</td>
<td>You don't have to meet deductibles for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>$1,000/individual or $2,000/family for In-Network Providers, $2,000/individual or $4,000/family for Out-of-Network Providers.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Services deemed not medically necessary by Medical Management and/or Anthem, Penalties for non-compliance, Non-Network Transplant Services, Premiums, balance-billing charges, and health care this plan doesn't cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td><strong>Will you pay less if you use a network provider?</strong></td>
<td>Yes, Blue Card PPO. See <a href="https://www.anthem.com">www.anthem.com</a> or call (844) 422-7714 for a list of network.</td>
<td>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</td>
</tr>
</tbody>
</table>
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.

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.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$15/visit deductible does not apply</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$25/visit deductible does not apply</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1 - Typically Generic</td>
<td>$8/prescription (retail) and $12/prescription (home delivery)</td>
<td>$40/prescription or 50% coinsurance, whichever is greater (retail)</td>
</tr>
<tr>
<td></td>
<td>Tier 2 - Typically Preferred/Brand</td>
<td>$25/prescription (retail) and $22/prescription or 10% coinsurance, whichever is greater (home delivery)</td>
<td>$40/prescription or 50% coinsurance, whichever is greater (retail)</td>
</tr>
<tr>
<td></td>
<td>Tier 3 - Typically Non-Preferred/Specialty Drugs</td>
<td>$40/prescription (retail) and $60/prescription or 10% coinsurance, whichever is greater (home delivery)</td>
<td>$40/prescription or 50% coinsurance, whichever is greater (retail)</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/eocdps/aso.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Tier 4 - Typically Specialty (brand and generic)</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Emergency room care</td>
<td>$200/visit deductible does not apply</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>10% coinsurance</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$40/visit deductible does not apply</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Outpatient services</td>
<td>Office Visit $15/visit deductible does not apply</td>
<td>Office Visit 30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Office visits</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Home health care</td>
<td>No charge</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$25/visit deductible does not apply</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Children’s eye exam</td>
<td>$15 or $25/visit deductible does not apply</td>
<td>30% coinsurance</td>
</tr>
</tbody>
</table>

*See Vision Services section

* See Therapy Services section

*Mandatory coverage under the Affordable Care Act (ACA) includes routine obstetric care for women and pregnancy-related services for pregnant women, including vision care for children under the age of 18 years. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).

*For more information about limitations and exceptions, see plan or policy document at [https://eoc.anthem.com/eocdps/aso](https://eoc.anthem.com/eocdps/aso).
Common Medical Event | Services You May Need | What You Will Pay | Limitations, Exceptions, & Other Important Information
--- | --- | --- | ---
If your child needs dental or eye care | Children’s glasses | Not covered | In-Network Provider (You will pay the least) Out-of-Network Provider (You will pay the most) *See Dental Services section
Children’s dental check-up | Not covered | Not covered | 

**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
- Dental care (adult)
- Infertility treatment
- Weight loss programs
- Acupuncture
- Dental Check-up
- Long-term care
- Cosmetic surgery
- Glasses for a child
- Routine foot care unless you have been diagnosed with diabetes.

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

- Bariatric surgery
- Most coverage provided outside the United States. See [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)
- Chiropractic care 12 visits/benefit period.
- Private-duty nursing is only covered in the home. 82 visits/benefit period.
- Hearing aids
- Routine eye care (adult)

**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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, [www.cciio.cms.gov](http://www.cciio.cms.gov). 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:

ATTN: **Grievances** and **Appeals**, P.O. Box 105568, Atlanta GA 30348-5568

Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, [www.cciio.cms.gov](http://www.cciio.cms.gov)

* For more information about limitations and exceptions, see plan or policy document at [https://eoc.anthem.com/eocdps/aso](https://eoc.anthem.com/eocdps/aso).
Does this plan provide Minimum Essential Coverage? Yes/No
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/No
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.

* For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/eocdps/aso.
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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)</th>
<th>Managing Joe’s type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia’s Simple Fracture (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td>■ The <strong>plan’s overall deductible</strong> $125</td>
<td>■ The <strong>plan’s overall deductible</strong> $125</td>
<td>■ The <strong>plan’s overall deductible</strong> $125</td>
</tr>
<tr>
<td>■ <strong>Specialist copayment</strong> $25</td>
<td>■ <strong>Specialist copayment</strong> $25</td>
<td>■ <strong>Specialist copayment</strong> $25</td>
</tr>
<tr>
<td>■ <strong>Hospital (facility) coinsurance</strong> 10%</td>
<td>■ <strong>Hospital (facility) coinsurance</strong> 10%</td>
<td>■ <strong>Hospital (facility) coinsurance</strong> 10%</td>
</tr>
<tr>
<td>■ <strong>Other coinsurance</strong> 10%</td>
<td>■ <strong>Other coinsurance</strong> 10%</td>
<td>■ <strong>Other coinsurance</strong> 10%</td>
</tr>
</tbody>
</table>

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)

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

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

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$12,840</th>
<th>$7,460</th>
<th>$2,010</th>
</tr>
</thead>
</table>

In this example, Peg would pay:

| **Cost Sharing** | Deductibles | $125 | Copayments | $0 | Coinsurance | $875 |
|---|---|---|---|---|---|

**What isn’t covered**
Limits or exclusions $60

The total Peg would pay is $1,060

In this example, Joe would pay:

| **Cost Sharing** | Deductibles | $120 | Copayments | $170 | Coinsurance | $13 |
|---|---|---|---|---|---|

**What isn’t covered**
Limits or exclusions $55

The total Joe would pay is $358

In this example, Mia would pay:

| **Cost Sharing** | Deductibles | $125 | Copayments | $775 | Coinsurance | $86 |
|---|---|---|---|---|---|

**What isn’t covered**
Limits or exclusions $0

The total Mia would pay is $986

The plan would be responsible for the other costs of these EXAMPLE covered services.
Language Access Services:

(TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjithën tuaj. Për të kontaktuar me një përkthyes, telefononi (844) 422-7714.

Amharic (አማርኛ): ያስ ምስ ይምህርስን ከ። ከተማው ከምምር ያስምት ምስምት ያስምት ከመስማው ብርሃን ከምምር ያስምት ከማስ-

Armenian (հայերեն): Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և

Bassa (Bassá Wúdù): M dyi dyi-die-dè bë bëcé bá céè-dè nià ke dyí ni, o mò ni dyi-bèèèin-dè bë m ke gbo- kpá-kpá ké bë kpó dé m bíjí-wùduùn bó pidíy. Bè m ke wuđu-zììn-nyò dò gbo wùduù ke, dá (844) 422-7714.

Bengali (বাংলা): যদি এই নথিগুলোর বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিস্মৃতি সাধারণ পাওয়ার ও ভাষায় পাওয়ার অধিকার আপনার আছে। একটি নোতামীয় সাথে কথা বলার জন্য (844) 422-7714।

Burmese (မြန်မာ): ဗိသားများ ဗိသားများ ဗိသားများ ဗိသားများ ဗိသားများ ဗိသားများ ဗိသားများ ဗိသားများ ဗိသားများ ဗိသားများ ဗိသားများ (844) 422-7714।

Chinese (中文): 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電 (844) 422-7714。

Dinka (Dinka): Na nąng thiéè cè ke de yá thòrè, ke yin nąng long bë yi kuony ku wer alèu bë geèt yic yin ne thòng du ke cin wët tāuè ke pìny. Te kɔ̀ yin bą jum wènè ran ye thok gertyic, ke yin còl (844) 422-7714.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (844) 422-7714.

Farsi (فارسی): در صورتی که سوالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ

French (Français): Si vous avez des questions sur ce document, vous avez la possibilité d’accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (844) 422-7714.
**Language Access Services:**

**German (Deutsch):** Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (844) 422-7714.

**Greek (Ελληνικά):** Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (844) 422-7714.

**Gujarati:** જે કે તમે આ દокументના પ્રાંતી સમયમાં કોઈ પ્રશ્ન કરી શકો છો, ત્યા સમયમાં તમારી ભાષામાં નક્કી સહાય અને માહિતી મળવી શકે છે. તમે અને મારું પર્વના માટે અંગે કોઈપણ સહાયક સાથે કાલ્પનિક કરી શકો છો, અને તેને કલમ કરી (844) 422-7714.

**Haitian Creole (Kreyòl Ayisyen):** Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (844) 422-7714.

**Hindi:** अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको नि:शुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है।

**Hmong (White Hmong):** Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (844) 422-7714.

**Igbo:** Ọ bụrụ na i nwere ajuụọ ọ bụla gbasara akwụkwọ ọ a, i nwere ikike ịnweta enyemaka na ozi ịn'asụṣụ gi na akwụghị ụgwọ ọ bụla. Ka gi na ọkọwa okwu kwuo okwu, kpọọ (844) 422-7714.

**Ilokano:** Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maya nga tagipatarus, awagan ti (844) 422-7714.

**Indonesian (Bahasa Indonesia):** Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (844) 422-7714.

**Italian (Italiano):** In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (844) 422-7714.

**Japanese:** この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(844) 422-7714 にお電話ください。
Language Access Services:

Khmer (ខេម្មៅ): ប្រើប្រាស់ប្រព័ន្ធមួយនេះដើម្បីអ舀រ: មិនចង់ប្រើប្រាស់ដុះពាក់ព្យាយាមខាងក្នុងដែលអាចប្រើប្រាស់មកពីអ្នកដែលមិនអាចប្រើប្រាស់ភាសាក្នុងប្រភេទក្រុមមនុស្សទាំងនេះ ទិញនូវការជួបជញ្ជូនខាងក្រោម (844) 422-7714 ។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvgishe umusemuzi, akura (844) 422-7714.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (844) 422-7714 로 문의하십시오.

Lao (ລາວ): ການធ្វើអំពីសេចក្តីថ្លែងការណ៍នេះ ត្រូវបានបង្ហាញច្បាស់ប្រការនៅក្នុងតំបន់ក្រុមមនុស្សដែលមានបញ្ហារបស់ពួកគេ។ និយាយសេចក្តីថ្លែងការណ៍របស់ពួកគេ តាមរយៈទូរស័ព្ទ (844) 422-7714.

Navajo (Diné): Dii naaltsoos biká’igii lahgo bina’idiílkidgeo ná bohóóneedzhá dóó bee ahóó’t’í’ t’áá ni nízaad k’éí bee nił hodooniih t’áadóó bááh ilínígóó. Ata’ halné’igíí la’ bich’í’ hateesdzihin níningo ko’i’ hodiilnih (844) 422-7714.

Nepali (नेपाली): यदि आप कार्यकालबारे तपाईंसंग केही प्रश्नहरू छन् भने, आफ्नो भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्ने तौली तपाईंसंग छ। तपाईंसंग कुरा गर्नका लागि, यहाँ कल गन्दुह्मा(844) 422-7714.

Oromo (Oromifaa): Sanadi kanaaa wajiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (844) 422-7714 bilbilla.


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