

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>. 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/ or call (833) 630-6741 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall calendar year deductible ?	\$0 /individual or \$0 /family for In- Network Providers . \$500 /individual or \$1,000 /family for Out-of- Network Providers .	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 ?	No.	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the calendar year out-of-pocket limit for this plan ?	\$3,000 /individual or \$6,000 /family for In- Network Providers . \$4,500 /individual or \$9,000 /family for Out-of- Network Providers . This plan has a separate Out of Pocket Maximum of \$1,000 /individual or \$2,000 /family for Prescription Drugs .	The calendar year 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 medical out-of-pocket limit ?	Prescription Drugs , Premiums , balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the medical out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes, KeyCare. See www.anthem.com or call (833) 630-6741 for a list of network	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

	providers .	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.

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	\$25/visit	30% coinsurance	-----none-----
	Specialist visit	\$50/visit	30% coinsurance	-----none-----
	Preventive care / screening /immunization	No charge	30% coinsurance	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)	20% coinsurance	30% coinsurance	-----none-----
	Imaging (CT/PET scans, MRIs)	\$200/visit then 20% coinsurance	30% coinsurance	-----none-----
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.WellDyneRx.com or by calling (888) 479-2000	Tier 1	\$10/prescription (retail) (30 day supply) \$30/prescription (retail) (90 day supply) and \$20/prescription (mail order)	\$10/prescription (30 day retail supply)	Retail pharmacy drugs are limited to a 30-day supply. A 90-day supply of maintenance medications are available at the retail level. Mail order drugs are limited to a 90-day supply.
	Tier 2	\$35/prescription (retail) (30 day supply) \$105/prescription (retail) (90 day supply) and \$70/prescription (mail order)	\$35/prescription (30 day retail supply)	Your plan uses a preferred drug list (formulary) which identifies the status of covered drugs. Some drugs may require preauthorization, while other drugs are subject to step therapy and quantity limit requirements. If the necessary preauthorization is not obtained, the drug may not be covered.
	Tier 3	\$70/prescription (retail) (30 day supply) \$210/prescription (retail) (90 day supply)	\$70/prescription (30 day retail supply)	If you visit an out-of-network pharmacy, you will pay the full cost of

* For more information about limitations and exceptions, see [plan](#) or **policy document** at <https://eoc.anthem.com/eocdps/aso>.

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)	
		\$140/prescription (mail order)		your prescription at the pharmacy then file a claim for reimbursement. Reimbursement will be based on what a participating pharmacy would receive had the prescription been filled at a participating pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$200/visit then 20% coinsurance	30% coinsurance	-----none-----
	Physician/surgeon fees	\$25 PCP/\$50 Spec./visit	30% coinsurance	-----none-----
If you need immediate medical attention	Emergency room care	\$200/visit then 20% coinsurance	30% coinsurance	-----none-----
	Emergency medical transportation	20% coinsurance	30% coinsurance	-----none-----
	Urgent care center	\$50/visit	30% coinsurance	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	\$400/admission then 20% coinsurance	30% coinsurance	-----none-----
	Physician/surgeon fees	20% coinsurance	30% coinsurance	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit \$25/visit Other Outpatient \$25/visit	Office Visit 30% coinsurance Other Outpatient 30% coinsurance	Office Visit -----none----- Other Outpatient -----none-----
	Inpatient services	\$400/admission then 20% coinsurance	30% coinsurance	-----none-----
If you are pregnant	Office Visits	\$25 PCP/\$50 Spec./visit	30% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Ob Dr. pre and post-natal care (global billed)	20% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	\$400/admission then 20% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	30% coinsurance	90 visits/benefit period.
	Rehabilitation services	\$50/visit then 20% coinsurance	30% coinsurance	*See Therapy Services section
	Habilitation services	20% coinsurance	30% coinsurance	
	Skilled nursing care	20% coinsurance	30% coinsurance	100 days limit/stay.
	Durable medical equipment	20% coinsurance	30% coinsurance	-----none-----

* For more information about limitations and exceptions, see [plan](#) or **policy document** at <https://eoc.anthem.com/eocdps/aso>.

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)	
	Hospice services	No charge	30% coinsurance	-----none-----
If your child needs dental or eye care	Children's eye exam	\$15/visit	\$30 allowance	*BVV Discounts offered on frames & lenses. See Vision Services section
	Children's glasses	Not covered*	Not covered	
	Children's dental check-up	Not covered	Not covered	*See Dental Services section

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 .)			
• Acupuncture	• Bariatric surgery	• Cosmetic surgery	
• Dental care	• Dental Check-up	• Long term care	
• Routine foot care unless you have been diagnosed with diabetes.	• Infertility treatment	• Weight loss programs	
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)			
• Chiropractic care 50 visits/benefit period.	• Most coverage provided outside the United States. See www.bcbsglobalcore.com	• Removal of impacted wisdom teeth	
• Routine eye care one eye exam/benefit period.			

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. 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.

* For more information about limitations and exceptions, see [plan](#) or **policy document** at <https://eoc.anthem.com/eocdps/aso>.

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 27401, Richmond, VA 23279

Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.cciio.cms.gov

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](#).

—————*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	\$0
■ Specialist copayment (3 visits)	\$50
■ Hospital (facility) copayment (1)	\$400
■ Other coinsurance	20%

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	\$12,800
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$550
Coinsurance	\$2,390
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,000

■ The plan's overall deductible	\$0
■ PCP copayment (4 visits)	\$25
■ Hospital (facility) copayment (1)	\$200
■ Other coinsurance	20%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#) (*4 scripts*12 mo.@\$35 ea*)
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,980
Coinsurance	\$27
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$2,059

■ The plan's overall deductible	\$0
■ Specialist copayment (6 visits)	\$50
■ Hospital (facility) copayment (1)	\$200
■ Other coinsurance	20%

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$500
Coinsurance	\$283
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$783

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 gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (833) 630-6741

Amharic (አማርኛ):- ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (833) 630-6741 ይደውሉ።

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (833) 630-6741.

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (833) 630-6741:

Bassa (Bàsɔ̀ Wùdù): M̐ dyi dyi-diè-dḙ bḙ bḙdḙ bá céè-dḙ nià kḙ dyí ní, ɔ̀ m̀ò nì dyí-bḙdḙin-dḙ bḙ m̐ kḙ gbo-kpá-kpá kḙ b̃ḙ kp̃ḙ dḙ m̐ bídí-wùdùün bó pídyi. Bḙ m̐ kḙ wuḍu-zìin-nyò d̀ò gbo wùdù kḙ, d́á (833) 630-6741.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (833) 630-6741 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (833) 630-6741 သို့ ခေါ်ဆိုပါ။

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 (833) 630-6741。

Dinka (Dinka): Na n̄ɔŋ thiēc nē ke de yā thorē, ke yin n̄ɔŋ loŋ bē yi kuony ku w̄er alēu bē ḡɛr yic yin ne thoŋ du ke cin wēu tāauē ke piny. Te k̄or yin ba jam wēnē ran ye thok geryic, ke yin c̄ol (833) 630-6741.

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 (833) 630-6741.

Farsi (فارسی): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (833) 630-6741 تماس بگیرید.

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 (833) 630-6741.

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 (833) 630-6741.

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 (833) 630-6741.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાડપણા સાથે વાત કરવા માટે, કોલ કરો (833) 630-6741.

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 (833) 630-6741.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (833) 630-6741 ।

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 (833) 630-6741.

Igbo (Igbo): O bụrụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (833) 630-6741.

Ilokano (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 maysa nga tagipatarus, awagan ti (833) 630-6741.

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 (833) 630-6741.

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 (833) 630-6741

Japanese (日本語): 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、(833) 630-6741 にお電話ください。

Language Access Services:

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។
ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅ (833) 630-6741 ។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuze, akura (833) 630-6741.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (833) 630-6741 로 문의하십시오.

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.
ເພື່ອໂອ້ນລັກກັບລ່າມແປພາສາ, ໃຫ້ໂທຫາ (833) 630-6741.

Navajo (Diné): Dií naaltsoos biká'ígíí lahgo bina'idílkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo báááh ilinígóó.
Ata' halne'ígíí la' bich'i' hadeesdzih nínízingo kojí' hodiilnih (833) 630-6741.

Nepali (नेपाली): यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ।
दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (833) 630-6741

Oromo (Oromifaa): Sanadi kanaa wajjin walqabaate gaffi kamiyyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (833) 630-6741 bilbilla.

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Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (833) 630-6741 ਤੇ ਕਾਲ ਕਰੋ।

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