### 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, visit [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 (855) 333-5730 to request a copy. For your Pharmacy benefits through Express-Scripts (Medco) go to [www.express-scripts.com](http://www.express-scripts.com) or call 1-877-554-3091.

<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>$500/person or $1,000/family for In-Network Providers, $500/person or $1,000/family for Non-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>Are there services covered before you meet your deductible?</td>
<td>Yes. Primary Care. Specialist Visit. Preventive Care. For more information see below.</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>Are there other deductibles for specific services?</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>$3,500/person or $7,000/family for In-Network Providers, $3,500/person or $7,000/family for Non-Network Providers. Prescription (Only In-network Providers): $2,350/person or $4,700/family.</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>Prescription Drug cost share out-of-network, any member prescription penalties (if applicable), 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>
</tbody>
</table>
Will you pay less if you use a **network provider**?
Yes, Prudent Buyer PPO. See [www.anthem.com/ca](http://www.anthem.com/ca) or call (855) 333-5730 for a list of network providers. Costs may vary by site of service and how the provider bills.

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.

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

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Non-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>$20/visit <strong>deductible</strong> does not apply</td>
<td>40% <strong>coinsurance</strong></td>
<td>Virtual visits (Telehealth) benefits available.</td>
</tr>
<tr>
<td><strong>Specialist</strong> visit</td>
<td>$20/visit <strong>deductible</strong> does not apply</td>
<td>40% <strong>coinsurance</strong></td>
<td>Virtual visits (Telehealth) benefits available.</td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>40% <strong>coinsurance</strong></td>
<td>You may have to pay for services that aren’t preventive. Ask your <strong>provider</strong> if the services needed are preventive. Then check what your <strong>plan</strong> will pay for.</td>
</tr>
</tbody>
</table>

---

If you have a test

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Non-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnostic test</strong> (x-ray, blood work)</td>
<td>20% <strong>coinsurance</strong></td>
<td>40% <strong>coinsurance</strong></td>
<td>-------none-------</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% <strong>coinsurance</strong></td>
<td>40% <strong>coinsurance</strong></td>
<td>$800 maximum/service for Non-Network Providers.</td>
</tr>
</tbody>
</table>

### Pharmacy OOPM

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Non-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out of Pocket Maximum (OOPM)</td>
<td>$2,350 Per Person/$4,700 Per Family</td>
<td>Non-Network claims do not apply to the OOPM</td>
<td>Member penalties including generic equivalent and retail refill allowance do not apply to the OOPM.</td>
</tr>
</tbody>
</table>

### If you need drugs to treat your illness or condition

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Non-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 - Typically Generic</td>
<td>$5 Co-pay (retail) $5 Co-pay (mail order)</td>
<td>$5 Co-pay (retail) Not Covered for mail order scripts</td>
<td>Covers up to a 30-day supply (retail prescription); up to a 90-day supply (mail order prescription).</td>
</tr>
<tr>
<td>Tier 2 - Typically <strong>Preferred</strong> / Brand</td>
<td>$20 Co-pay (retail) $40 Co-pay (mail order)</td>
<td>$20 Co-pay (retail) Not Covered for mail order script</td>
<td>For brand drugs that have a generic equivalent available: Member may pay the generic co-pay plus the difference in cost</td>
</tr>
</tbody>
</table>

---

* 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).
<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>More information about <strong>prescription drug coverage</strong> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a></td>
<td>Tier 3 - Typically Non-Preferred / Specialty Drugs</td>
<td>In-Network Provider (You will pay the least)</td>
<td>Non-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$60 Co-pay (retail)</td>
<td>$60 Co-pay (retail) Not Covered for mail order script</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$120 Co-pay (mail order)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 4 - Typically Specialty (brand and generic)</td>
<td>20% to $150 max (retail) 20% to $300 max (mail order)</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$50/visit, then 20% coinsurance</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$20/visit deductible does not apply</td>
<td>40% coinsurance</td>
</tr>
</tbody>
</table>

* 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).
<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>Non-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office Visit $20/visit deductible does not apply Other Outpatient 20% coinsurance</td>
<td>Office Visit 40% coinsurance Other Outpatient 40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>$20/visit deductible does not apply</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No charge</td>
<td>40% coinsurance</td>
</tr>
</tbody>
</table>

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

$500 penalty if Non-Network preauthorization is not obtained.
$600 maximum/day for Non-Emergency Admissions to Non-Network Providers.
<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>Non-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

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.)

- Cosmetic surgery
- Dental Check-up
- Hearing aids
- Routine eye care (Adult)
- Dental care (Adult)
- Eye exams for a child
- Infertility treatment
- Routine foot care unless you have been diagnosed with diabetes
- Dental care (Pediatric)
- Glasses for a child
- Long-term care
- Weight loss programs

Pharmacy Benefit Exclusions

- Allergy Serums
- Drugs used to promote or stimulate hair growth
- Non-Federal Legend Drugs
- Drugs labeled “Caution-limited by Federal law to investigational use” or experimental drugs, even though a charge is made to the individual
- ACA Preventive Meds Aspirin – Exception: covered for adults under 70 years of age
- ACA Preventive Meds Smoking Cessation- Exception: covered for adults 18 years of age and over
- ACA Preventive Meds – Vitamin D Exception: Covered for adults age 65 years of age and over
- ACA Preventive Meds Folic Acid- Exception: covered for adults under 51 years of age
- ACA Preventive Meds - Breast Cancer Prevention, Exception: covered for adults 35 years of age and over
- ACA Preventive Meds Contraceptives – Exception: covered for adults less than 51 years of age
- ACA Preventive Meds Fluoride-Exception: covered for children 6 months through 5 years of age
- ACA Preventive Meds- Bowel Prep Agents Exception: covered for adults between the ages of 50 through 75 years
- ACA Preventive Meds – Statins Exception: Covered for adults 40-75 years of age
- Biologicals
- Blood or blood plasma products
- Nutritional Supplements
- Some or certain compounds are excluded
- ACA Preventive Meds Contraceptives – Exception: covered for adults less than 51 years of age
- ACA Preventive Meds Fluoride-Exception: covered for children 6 months through 5 years of age
- ACA Preventive Meds- Bowel Prep Agents Exception: covered for adults between the ages of 50 through 75 years
- ACA Preventive Meds – Statins Exception: Covered for adults 40-75 years of age
- Drugs used for cosmetic purposes
- Insulin Pumps
- Ostomy Supplies
- ACA Preventive Meds Contraceptives – Exception: covered for adults less than 51 years of age
- ACA Preventive Meds Fluoride-Exception: covered for children 6 months through 5 years of age
- ACA Preventive Meds- Bowel Prep Agents Exception: covered for adults between the ages of 50 through 75 years
- ACA Preventive Meds – Statins Exception: Covered for adults 40-75 years of age

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

- Acupuncture 20 visits/benefit period
- Most coverage provided outside the United States. See www.bcbsglobalcore.com
- Bariatric surgery
- Private-duty nursing in a Home Setting only
- Chiropractic care 30 visits/benefit period

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

- Specialty Drugs
- Insulin
- OTC Diabetic Supplies (except Insulin Pumps and Glucowatch products)
- ACA Preventive Meds Aspirin – Exception: covered for adults under 70 years of age
- ACA Preventive Meds Smoking Cessation - Exception: covered for adults 18 years of age and over
- ACA Preventive Meds - Statins Exception: Covered for adults 40-75 years of age
- State Restricted Drugs
- Needles and Syringes
- ACA Preventive Meds Contraceptives – Exception: covered for adults less than 51 years of age
- ACA Preventive Meds Folic Acid- Exception: covered for adults under 51 years of age
- ACA Preventive Meds - Breast Cancer Prevention, Exception: covered for adults 35 years of age and over
- Vaccines
- Drugs to treat Impotency for males only age 18 and over
- ACA Preventive Meds – Vitamin D Exception: Covered for adults age 65 years of age and over
- ACA Preventive Meds Fluoride -Exception: covered for children 6 months through 5 years of age
- ACA Preventive Meds- Bowel Prep Agents Exception: covered for adults between the ages of 50 through 75 years
- ACA Preventive Meds HIV – Exception: Covered for Generic Only

### 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: California Department of Insurance, Consumer Services Division, 300 South Spring Street, South Tower, Los Angeles, CA 90013, (800) 927-HELP (4357), 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.

### 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 on how 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 4310, Woodland Hills, CA 91365-4310


California Department of Insurance, Consumer Communications Bureau, 300 South Spring Street, South Tower, Los Angeles, CA 90013, 1-800-927-HELP (4357), 1-213-897-8921, 1-800-482-4TDD (4633), www.insurance.ca.gov/

### Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

### Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

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* 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 plan’s overall deductible</td>
<td>The plan’s overall deductible</td>
<td>The plan’s overall deductible</td>
</tr>
<tr>
<td>Specialist copayment</td>
<td>Specialist copayment</td>
<td>Specialist copayment</td>
</tr>
<tr>
<td>Hospital (facility) coinsurance</td>
<td>Hospital (facility) coinsurance</td>
<td>Hospital (facility) coinsurance</td>
</tr>
<tr>
<td>Other coinsurance</td>
<td>Other coinsurance</td>
<td>Other coinsurance</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)

**Total Example Cost** $12,700

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$500</td>
<td>$500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
<td>$20</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,400</td>
<td>20%</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions $70
- The total Peg would pay is $2,970

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** $5,600

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td>Copayments</td>
<td>$200</td>
<td>$200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
<td>20%</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions $4,300
- The total Joe would pay is $4,600

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** $2,800

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$500</td>
<td>$500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$300</td>
<td>20%</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions $10
- The total Mia would pay is $910

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 1-888-254-2721

Amharic (አማርኛ): ከአማርኛ ይታሸጥ ከአማርኛ ይታሸጥ ከአማርኛ ይታሸጥ ከአማርኛ ይታሸጥ ከአማርኛ ይታሸጥ ከአማርኛ ይታሸጥ ከአማርኛ ይታሸጥ ከአማርኛ ይታሸጥ ከአማርኛ 1-888-254-2721

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيرجى للحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على 1-888-254-2721

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ 1-888-254-2721:

Bassa (Bësë Wùqù): Ì dì yì dì-yìè që bë bëdë há cëè-dë nià ke dyì ni, c mò nì dì-yìè-dë që bë m ke gbo-kpá-kpá ke bò kpó dë m bìdì-wùqùún bò pidìyì. Bë m ké wùdu-zìni-nyò dò gbo wùqù ke, dâ 1-888-254-2721.

Bengali (বাংলা): যদি এই বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষার বিনামূল্য সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোকানির সাথে কথা কাটার জন্য 1-888-254-2721 -তে কল করুন।

Burmese (မြန်မာဘာသာ): မြန်မာဘာသာမှ သို့မဟုတ် အင်္ဂလိပ်မှ သို့မဟုတ် အချင်းချင်း အခြေခံသည် အဆင့်မြင့်သည် အဆင့်မြင့်သည် အဆင့်မြင့်သည် အဆင့်မြင့်သည် အဆင့်မြင့်သည် အဆင့်မြင့်သည် 1-888-254-2721

Chinese (中文): 如果您对本文件有任何疑问，您有权使用您的语言免费获得协助和资讯。如需与译员通话，请致电1-888-254-2721。

Dinka (Dinka): Na nang thiee ne ke de ya thore, ke yin nang log be yi kuony ku wer akew be gec yic yin ne thon du ke cin wew taeu ke piny. Te kor yin ba jam wene ran ye thok genyi, ke yin col 1-888-254-2721.

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 1-888-254-2721.
Language Access Services:

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 1-888-254-2721.

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 1-888-254-2721.

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 1-888-254-2721.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્ન થોડી થોડી તો, કોઈપણ અભયાંગ વગર આપની ભાષામાં મદદ અને માહિતી મળવામાં તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો 1-888-254-2721.

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 1-888-254-2721.

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। दुभाषियों से बात करने के लिए, कॉल करें 1-888-254-2721.


Igbo (Igbo): Ṫụrụ na ị nwere ajụjụ o bụla gbasara akwụkwọ a, ị nwere ikike ānweta enyemaka na ozi n'aṣiṣu ị na akwụghị ụgwọ o bụla. Ka ị na ọkọwa okwu kwuo okwu, kpọọ 1-888-254-2721.

Ilokano (Ilokano): Nu addaan ka iti animanan 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 1-888-254-2721.

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 1-888-254-2721.

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 1-888-254-2721.

Japanese (日本語): この文書についてなら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 1-888-254-2721 にお電話ください。
Language Access Services:

Khmer (ខ្មែរ): ប្រើប្រាស់ពាក្យភាសាខ្មែរនំអិរញ្ញវត្ថុជាមួយនេះ: អ្នកមានសុវត្ថិភាពនូវប្រព័ន្ធផ្តល់ជម្រើសដំណើរការនេះមកជំនាញអ្នក។ ប្រើប្រាស់លេខទូរស័ព្ទការិយាល័យ៖ 1-888-254-2721

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura 1-888-254-2721.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 1-888-254-2721로 문의하십시오.

Lao (ລາວ): ແຈ້ງການປະຕິບັດຕິດຕາມລາວແລ້ວຄັ້ງອັນດິນທັງໝັ້ນ, ໄດ້ຮູບຮ່ວມໄຟແລກທີ່ອັນດິນທັງໝັ້ນ ແລະ ມີສ່ວນສ່ວນຈາກຕາມຄົງລາວແລ້ວຄັ້ງອັນດິນທັງໝັ້ນ. ເໜືອຊ່ວຍຄັ້ງອັນດິນທັງໝັ້ນ 1-888-254-2721.

Navajo (Diné): Díí naaltsoos biká’ígíí laahgo bina’ídiikidgo ná bóho néédza dóó bee ahóó’í t’áá ni nízaad k’éhí bee nił hodooníí t’aadoo bíí báah’ ilíníígo. Ata’ halné’ígíí la’ bích’íí hadeesdíízh níniínggo kojíí hodíilííh 1-888-254-2721.

Nepali (नेपाली): यदि आप जानातांबारे तपाईं के प्रश्न हृदय छनौँ भने, आफ्नो भाषामा निजीक तपाईं देखि जानकारी प्राप्त गर्न पाउने एक तपाईं छ। दोमाषे संग गर्नका लागि, यहीं कल गर्नुहोस् 1-888-254-2721

Oromo (Oromifaa): Sanadi kanaa wajiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaama dubaachuuf, 1-888-254-2721 bilbilla.


Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-888-254-2721.

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Punjabi (ਪੰਜਾਬੀ): ਸੁਨਾਈ ਦੇਸ਼ ਦੇ ਸਰਕਾਰ ਦੇ ਸੇਵਕ ਦੀ ਸ਼ਾਂਤੀ ਦੇ ਲਾਗੂ ਆਂਦੋਲਨ ਦੀ ਜਿੱਤ ਪ੍ਰਾਪਤ ਹੋਣ ਦੋ ਸੇਵਕ ਦੀ ਭਾਵਨਾ ਕੀਤੀ। ਸੇਵਕ ਨੂੰ ਬ੍ਰਤੀ ਰਾਖਣ ਲਈ 1-888-254-2721 ਆਲੋਚਨਾ, ਕਾਲ 16.27.
Language Access Services:

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Russian (Русский): Если у вас есть какие-либо вопросы в отношении данного документа, вы имеет право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. 1-888-254-2721.

Samoan (Samoa): Afai e iai ni ou fesili e uiga i lenei tusi, e iai lou ‘aia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se totogi. Ina ia talanoa i se tagata faaliliu, vili 1-888-254-2721.


Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al 1-888-254-2721.

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Thai (ไทย): หากคุณมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร 1-888-254-2721 เพื่อพูดคุยกับล่าม

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Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi 1-888-254-2721.

Yiddish (אידיש):Azoy, that ayer fun sheltslakh ve yudn di kumenik, hinei ir fun dere, ves kumenik, vese a yidnferatsen, un a sheyn fun dere. 1-888-254-2721.

Yoruba (Yorùbá): Tí o bá ní èyikèyì ibù rí ìpà àkọ sílà yì, o ní èyì ló tí gbà íranwò àti ìwífìn ní èdè rẹ lójèè. Bá wa ọgbùfù kan sórọ, pe 1-888-254-2721.
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