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://ecp.anthem.com/eocdp/aso](https://ecp.anthem.com/eocdp/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/](http://www.healthcare.gov/sbc-glossary/) or call (855) 634-3383 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0.</td>
<td>See the Common Medical Events chart below for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Primary Care. Specialist Visit. Preventive Care. Certain Prescription Drugs. Children's eye exam. 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>What is the out-of-pocket limit for this plan?</td>
<td>$4,000/person or $8,000/family for In-Network Providers. This plan has a separate Out of Pocket Maximum of $5,000/single or $10,000/family for Prescription Drugs.</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>What is not included in the out-of-pocket limit?</td>
<td>Prescription Drugs, Home health care, Hearing aids, 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>Will you pay less if you use a network provider?</td>
<td>Yes, HMO. See <a href="http://www.anthem.com">www.anthem.com</a> or call (855) 634-3383 for a list of network providers. Costs may vary by site of service and how the provider bills.</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 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.</td>
</tr>
<tr>
<td>Do you need a <strong>referral</strong> to see a <strong>specialist</strong>?</td>
<td>No.</td>
<td>You can see the <strong>specialist</strong> you choose without a <strong>referral</strong>.</td>
</tr>
</tbody>
</table>

---

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>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>If you visit a health care provider's office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>$10/visit</td>
<td>Not covered</td>
<td>Virtual visits (Telehealth) benefits available.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$30/visit</td>
<td>Not covered</td>
<td>Virtual visits (Telehealth) benefits available.</td>
</tr>
<tr>
<td></td>
<td>Preventive care / screening / immunization</td>
<td>No charge</td>
<td>Not covered</td>
<td>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.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
<td>Not covered</td>
<td>----none------</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$75/visit</td>
<td>Not covered</td>
<td>----none------</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Tier 1 - Typically Generic</td>
<td>20% <strong>coinsurance</strong> (30-day Rx) 10% <strong>coinsurance</strong> (90-day Rx at UK Pharmacy or Express Scripts Home Delivery)</td>
<td>Not covered (retail and home delivery)</td>
<td>$8 minimum/$50 maximum (30-day Rx, any pharmacy) $24 minimum/$100 maximum (90-day Rx UK Phcy/Mail Order)</td>
</tr>
<tr>
<td></td>
<td>Tier 2 - Typically Preferred Brand &amp; Non-Preferred Generic Drugs</td>
<td>40% <strong>coinsurance</strong> (30-day Rx) 30% <strong>coinsurance</strong> (90-day Rx at UK Pharmacy or Express Scripts Home Delivery)</td>
<td>Not covered (retail and home delivery)</td>
<td>$20 minimum/$60 maximum (30-day Rx any pharmacy) $60 minimum/$120 maximum (90-day Rx UK Phcy/Mail Order)</td>
</tr>
<tr>
<td></td>
<td>Tier 3 - Typically Non-Preferred Brand and Generic drugs</td>
<td>50% <strong>coinsurance</strong> (30-day Rx) 40% <strong>coinsurance</strong> (90-day Rx at UK Pharmacy or Express Scripts Home Delivery)</td>
<td>Not covered (retail and home delivery)</td>
<td>$60 minimum (30-day Rx any pharmacy) $120 minimum (90-day Rx UK Phcy/Mail Order)</td>
</tr>
<tr>
<td></td>
<td>Tier 4 - Specialty Generic</td>
<td>20% <strong>coinsurance</strong></td>
<td>Not covered (retail and home delivery)</td>
<td>$8 minimum/$50 maximum (per 30-day Rx)</td>
</tr>
<tr>
<td></td>
<td>Tier 4 - Specialty Brand</td>
<td>$200 per 30-day Rx</td>
<td>Not covered (retail and home delivery)</td>
<td>----none------</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$75/visit</td>
<td>Not covered</td>
<td>----none------</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>Not covered</td>
<td>----none------</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see [plan](https://eoc.anthem.com/eocdps/aso) 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>In-Network Provider (You will pay the least)</td>
<td>Non-Network Provider (You will pay the most)</td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$100/visit then 20% coinsurance</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$75/trip</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$25/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Facility fee (e.g., hospital room)</td>
<td>$200/admission</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Outpatient services</td>
<td>Office Visit $10/visit, Other Outpatient No charge</td>
<td>Office Visit Not covered, Other Outpatient Not covered</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>$200/admission</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Office visits</td>
<td>$30 initial visit only</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$200/admission</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Home health care</td>
<td>20% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$15/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$15/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Durable medical equipment</td>
<td>20% coinsurance, up to $500 out-of-pocket limit/plan year</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

* See Therapy Services section.

* For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/eocdps/aso.
<table>
<thead>
<tr>
<th>If your child needs dental or eye care</th>
<th>Children’s eye exam</th>
<th>$10/visit</th>
<th>Not covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

*See Vision Services section

---

If your child needs dental or eye care

<table>
<thead>
<tr>
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<th>$10/visit</th>
<th>Not covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

*See Vision Services section

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

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered).
- Dental care ( Pediatric)
- Long-term care
- Routine eye care (Adult)
- Cosmetic surgery
- Dental Check-up
- Non-emergency care when traveling outside the U.S
- Routine foot care unless you have been diagnosed with diabetes.
- Dental care (Adult)
- Glasses for a child
- Private-duty nursing
- Weight loss programs

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

- Acupuncture 45 visits/benefit period for physical therapy, occupational therapy, speech therapy, Cardiac therapy, and manipulative treatment.
- Spinal Manipulation 45 visits/benefit period for physical therapy, occupational therapy, speech therapy, Cardiac therapy, and Acupuncture.
- Bariatric surgery
- Hearing aids 1 item/ear every 36 months for children 18 years of age or under.

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 Insurance, 215 West Main Street, Frankfort, Kentucky 40601, (502) 564-3630, (800) 595-6053, TTY: (800) 648-6056, 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 105568, Atlanta GA 30348-5568


* For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/eocdps/aso.
Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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.

* For more information about limitations and exceptions, see plan or policy document at https://eoc.anthemp.com/eocdps/aso.
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**: $30
- **Hospital (facility) copayment**: $200
- **Other coinsurance**: 0%

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>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$0</td>
<td>$200</td>
<td>$0</td>
</tr>
</tbody>
</table>

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

**The total Peg would pay is**: $260

### Managing Joe’s Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan’s overall deductible**: $0
- **Specialist copayment**: $30
- **Hospital (facility) copayment**: $200
- **Other coinsurance**: 0%

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>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$0</td>
<td>$100</td>
<td>$1,600</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $20

**The total Joe would pay is**: $1,720

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

- **The plan’s overall deductible**: $0
- **Specialist copayment**: $30
- **Hospital (facility) copayment**: $200
- **Other coinsurance**: 0%

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>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$0</td>
<td>$400</td>
<td>$100</td>
</tr>
</tbody>
</table>

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

**The total Mia would pay is**: $500

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

(TTY/TDD: 711)

Albanian (Shqip): Nëse kenë pyetje në lidhje me këtë dokument, ken është drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për t’ë kontaktuar me një përkthyes, telefononi (855) 634-3383

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فتحلى لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (855) 634-3383.

Armenian (հայերեն): Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հենց (855) 634-3383:


Bengali (বাংলা): যদি এই লেখিকার বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্য সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন ভাষায়িক সাথে কথা বলার জন্য (855) 634-3383 -তে কল করুন।

Burmese (မြန်မာ): မိစ္စာဖာစာများအပါအဝင် တွေ့ရှိနေတဲ့ အခြေခံ ကွဲပြားမှုများထဲမှ အားလုံးကို တွေ့ရှိနေတယ်ကြောင့် ကြိုးစားမှုများကို ချခ်ပါစ်တစ်ချက်အထိ ထွက်ရှိနေတယ်။ အချင်းအရာတစ်ချက်အတွက် (855) 634-3383 ဆက်ဆဂာနိုင်ပါသည်။

Chinese (中文)：如果您对本文件有任何疑问，您有权利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(855) 634-3383。

Dinka (Dinka): Na nong thiécc nê ke de ya thôre, ke yin nong log bê yi kuony ku wer aleu bê geer yic yin ne thôj du ke cin wêu tââuê ke pîny. Te kôr yin ba jêm wênê ran ye thok geryic, ke yin col (855) 634-3383.

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 (855) 634-3383.
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 (855) 634-3383.

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 (855) 634-3383.

Greek (Ελληνικά): Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε τη δυνατότητα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (855) 634-3383.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અને આપની કોઈપણ પ્રશ્ન હોય તો, આપની ભાષામાં મદદ અને માહહતી મેળવવા તમને અહ્યકાર છે. દુભાષયા સાથે વાત કરવા માટે, કોલ કરો (855) 634-3383.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn eò ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (855) 634-3383.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज के बारे में कोई प्रश्न है, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (855) 634-3383.


Igbo (Igbo): Ọ bụrụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ikweta enyemaka na ozi n'asụṣụ gi na akwụghị ụgwọ ọ bụla. Ka gi na ọkọwa okwu kwuo okwu, kpọọ (855) 634-3383.

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 (855) 634-3383.

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 (855) 634-3383.

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 (855) 634-3383.

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Khmer (ខ្មែរ): ប្រឈមជីវិតប្រសើរដោយរៀងរាល់អតិថិជនរាជធានី ឬអនុសញ្ញា ១៩៤៦ ១៩៤៨ ក្នុងរៀងរាល់ប្រជាជនខ្មែរសីលធម៌។ ទិញប្រវត្តិសាស្ត្រជាតិប្រការនៃ ៨៨៧ (855) 634-3383 ៣។

Kirundi (Kirundi): Ugize ikibazo ico arico kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (855) 634-3383.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (855) 634-3383로 문의하십시오.

Lao (ລາວ): ហេតុនេះគឺជាការទទួលបានការជួយនឹងប្រធានាធិបតី ហើយក្រោយព្រមារបស់អ្នកប្រធានាធិបតី ហើយក្រោយព្រមារបស់អ្នកប្រធានាធិបតី។ ចុះឈ្នះការពន្យល់ពីប្រធានាធិបតី (855) 634-3383.

Navajo (Diné): Dzi naalssoos biká’ígi’ lahgo bina’idikidgo ná bohóneedzą dóó bee ahóot’i’ t’áá ni nizaad k’ehj bee nil hodoonih t’áadoo bááh ilinigóó. Ata’ halne’ígii’ la’ bich’i’ hadeesdzih ninizingo koj’ hodiilnííh (855) 634-3383.

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Punjabi (ਪੰਜਾਬੀ): ਨੇ ਜਾ ਦੇਵੇ ਦੇਵ ਦਾ ਨਸਤਰ ਵਾਲੇ ਵੇਲੇ ਨਾਲ ਸਿੰਧ ਬਾਲੇ ਤੇ ਨਾਲ ਦਾ ਦੱਸਦਰ ਸੱਭ ਦਾ ਸ਼ਾਸਕ ਅਧਿਕਾਰ ਦੁਆਲੇ। ਫਿਰਮ ਪੰਜਾਬੀ ਲੋਕ ਨੋਲ ਬਾਲਿ ਸੰਦਰ (855) 634-3383 ਦੇ ਬਾਸਤ ਵਧਾ।
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Yiddish (אידיש): זא צו טעמלнтерעפשונג, ראו גיטלעפֿบางע שומע.way, (855) 634-3383. (אידיש) (Yiddish)

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