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://ec. anthem.com/ecodps/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 (844) 736-0920 to request a copy.

<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>$450/person or $1,350/family for In-Network Providers, $1,800/person or $5,400/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><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. 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><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>$1,800/person or $5,400/family for In-Network Providers, $7,200/person or $14,400/family for Non-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>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 Access. See <a href="http://www.anthem.com">www.anthem.com</a> or call (844) 736-0920 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>Common Medical Event</td>
<td>Services You May Need</td>
<td>In-Network Provider (You will pay the least)</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>---------------------------------------------</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>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1 - Typically Generic</td>
<td>$10/prescription, deductible does not apply (retail) and $25/prescription, deductible does not apply (home delivery)</td>
</tr>
<tr>
<td></td>
<td>Tier 2 - Typically Preferred Brand &amp; Non-Preferred Generic Drugs</td>
<td>$25/prescription, deductible does not apply (retail) and $60/prescription, deductible does not apply (home delivery)</td>
</tr>
<tr>
<td></td>
<td>Tier 3 - Typically Non-Preferred Brand and Generic drugs</td>
<td>$75/prescription, deductible does not apply (retail) and $180/prescription, deductible does not apply (home delivery)</td>
</tr>
<tr>
<td></td>
<td>Tier 4 - Typically Preferred Specialty (brand and generic)</td>
<td>$20 Generic $60 Preferred Brand $180 Non-Preferred Brand Copayment per prescription (30-day quantity limit)</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$150/visit deductible does not apply</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>---------------------</td>
<td>------------------------------------</td>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td>Urgent care</td>
<td>$75/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).
| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|----------------------|-----------------------|-------------------|-----------------|
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | **In-Network Provider** (You will pay the least) | **Non-Network Provider** (You will pay the most) | 90 days/benefit period for Inpatient physical medicine, rehabilitation including day rehabilitation programs and skilled nursing services combined |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance |  |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office Visit | Office Visit | Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient |
| | | 20% coinsurance | 40% coinsurance |  |
| | | Other Outpatient | Other Outpatient |  |
| | | 20% coinsurance | 40% coinsurance |  |
| | Inpatient services | 20% coinsurance | 40% coinsurance |  |
| **If you are pregnant** | Office visits | 20% coinsurance | 40% coinsurance | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 20% coinsurance | 40% coinsurance |  |
| | Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance |  |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 40% coinsurance | 60 visits/benefit period |
| | Rehabilitation services | 20% coinsurance | 40% coinsurance | *See Therapy Services section. |
| | Habilitation services | 20% coinsurance | 40% coinsurance | 90 days/benefit period for Inpatient physical medicine, rehabilitation including day rehabilitation programs and skilled nursing services combined. |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | *See Durable Medical Equipment Section |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance |  |
| | Hospice services | No charge | No charge |  |
| **If your child needs dental or eye care** | Children’s eye exam | No charge | 40% coinsurance |  |
| | Children’s glasses | Not covered | Not covered |  |
| | Children’s dental check-up | Not covered | Not covered |  |

*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).*
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
- Dental care (Adult)
- Infertility treatment
- Routine foot care unless medically necessary
- Dental care (Pediatric)
- Glasses for a child
- Long-term care
- Weight loss programs
- Cosmetic surgery
- Dental Check-up
- Hearing aids (Adult)
- Bariatric surgery

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

- Chiropractic care 12 visits/benefit period
- Eye exams for a child
- Most coverage provided outside the United States. See www.bcbsglobalcore.com
- Private-duty nursing in a home setting only
- 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: State of Indiana Department of Insurance, 311 W. Washington Street, Suite 300, Indianapolis, Indiana 46204, (800) 622-4461, (317) 232-2395, www.in.gov/idoi/3008.htm, 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


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.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.

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)

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)

This EXAMPLE event includes services like:

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

---

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan’s overall deductible: $450
- Specialist coinsurance: 20%
- Hospital (facility) coinsurance: 20%
- 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: $12,700

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$450</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,350</td>
</tr>
</tbody>
</table>

What isn’t covered - Limits or exclusions: $70

The total Peg would pay is $1,870

---

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

- The plan’s overall deductible: $450
- Specialist coinsurance: 20%
- Hospital (facility) coinsurance: 20%
- Other coinsurance: 20%

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>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$450</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,030</td>
</tr>
</tbody>
</table>

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

The total Joe would pay is $1,500

---

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

- The plan’s overall deductible: $450
- Specialist coinsurance: 20%
- Hospital (facility) coinsurance: 20%
- 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: $2,800

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$450</td>
</tr>
<tr>
<td>Copayments</td>
<td>$150</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$470</td>
</tr>
</tbody>
</table>

What isn’t covered - Limits or exclusions: $10

The total Mia would pay is $1,080

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 t’i kon taktuar me një përkthyes, telefononi (844) 736-0920

Amharic (አማርኛ): ከእለም ከወረድ ያማርኛ ከተማ ከምር ያማርኛ ከተማ ከማርኛ ከተማ ከማርኛ ከተማ ከማርኛ ከተማ ከማርኛ ከተማ ከማርኛ (844) 736-0920 ይደውሉ።

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا الملف، فتحقد الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (844) 736-0920.

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, ձեք իրավունք ունեք ստանալ օգնություն և տեղեկություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (844) 736-0920.


Bengali (বাংলা): বাংলা ভাষায় কথার মাধ্যমে এই ডকুমেন্টের বিষয়ে প্রশ্ন করুন, যেহেতু আপনার ভাষায় সাহায্য পাওয়া ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন অভিব্যক্তির সাথে কথা কথার জন্য (844) 736-0920 -ভে কল করুন।

Burmese (ဘာသာ): မိုးစိတ်ကျင်းရုံးသို့ လိုအပ်သော အချက်အလက်များစာရင်းကို ရေးထားပါက မိုးစိတ်ကျင်းရုံးကို အတွက် ဖြင့် အသိအမှတ်ရှိသော အချက်အလက်များစာရင်းကို ရေးထားပါက (844) 736-0920 -သို့ ကြည်ပြောပါ။

Chinese (中文): 如果您对本文件有任何疑问，您有权限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 (844) 736-0920。

Dinka (Dinka): Na nga thëcë nê ke de ya thorë, ke yin nga loq bê yi kuony ku wèr aleu bê geër yi yin ne thong dë ke cin wêu tâuë ke piny. Te kôr yin ba jaam wênë ran ye thok getyic, ke yin col(844) 736-0920.

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) 736-0920.
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 (844) 736-0920.

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) 736-0920.

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, τηλεφονήστε στο (844) 736-0920.

Gujarati (ગુજરાતી): જો આ દર્શાવેલી અંગં આપને કોઈપણ પ્રશ્ન કોય તો, કોઈપણ પ્રશ્ન પર આપની ભાષામાં મદદ અને માહેસ્થાની મેળવવાનો તમને અહિકાર છે. દૂઃખાયાય સાથે વાત કરવા માટે, કોલ કરો (844) 736-0920.

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) 736-0920.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज के बारे में कोई प्रश्न हैं, तो आपको निष्ठुल 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 tstm xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (844) 736-0920.

Igbo (Igbo): Ọ bụrụ na ụ nwere ajụjụ ọ bula gbasara akwụkwọ a, ụ nwere ikike ịnweka enye maka na ozi n'asụṣụ ị na akwụghị ọgwọ ọ bula. Ka ị na ọkọwa okwu kwuo okwu, kpọ (844) 736-0920.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguaem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (844) 736-0920.

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) 736-0920.

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) 736-0920.

Japanese (日本語): この文書についても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) 736-0920 にお電話ください。
Language Access Services:

Khmer (ប្រ៊ុក): ប្រឈមប្រាក់អំពីនេះត្រូវបានបង្កើតឡើងដោយសារព័ត៌មាន។ អំពីការសម្រេចការបញ្ចូលការបង្កើតប្រការបញ្ជីផ្នែកអំពីរបស់អ្នកដែលបានបង្កើតឡើង។ សេវាកម្មសម្រាប់អ្នកអាចនឹកឈ្មោះពាក្យស្រុក់គ្នាដោយសារព័ត៌មាន (844) 736-0920។

Kirundi (Kirundi): Uğize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (844) 736-0920.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (833) 578-4441 로 문의하십시오.

Lao (ລາວ): ບໍ່ສາມາດໃຫ້ຄູານການວ່າງການຂາຍຂອງແຫ້ງ່າງນີ້, ບໍ່ສາມາດໃຫ້ຄູານການຂາຍຂອງແຫ້ງ່າງນີ້ໄດ້ຮູບພາບຢູ່ເຂົ້າຢູ່ງໜ້າ ແລະ ຜູ້ແຫ້ງ່າງເລືອກອົງການໂຄງການໄວ້. ສໍາລັບອັນງາມວ່າແມ່ນບໍ່ມີ, ແຕ່ໄດ້ທີ່ (844) 736-0920.

Navajo (Diné): Díí naaltsoos biká’ígii łahgo bina’idlikdgo ná bohónéézhí dóó bee ahóot’í’ t’áá ni nízaad k’ééhí bee nil hodooih t’áadoo báázh ilinígóó. Ata’ halne’ígii la’ bich’é’ hadeesdzíh ninizingo kojí’ hodílñiní (844) 736-0920.

Nepali (नेपाली): यदि यो कार्यालय तथा परिसर के सभी प्रश्नों को समझना चाहते हैं, तो आपका भाषा की विशेषता सहयोग तथा व्यक्तिगत प्राप्ति वर्ग पाएं होता है। दोबारा संवाद करने का माध्यम है (844) 736-0920.

Oromo (Oromifaa): Sanadi kanaa wajiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (844) 736-0920 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 (844) 736-0920.

Portuguese (Português): Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para (844) 736-0920.

Punjabi (ਪੰਜਾਬੀ): ਨੇ ਜਾਣਕੰਦੇ ਕੀਮਤ ਦਾ ਘਾਟ ਪਾਣੇ ਵੇਦੀ ਸਹਾਲ ਦੁੱਖ ਉੱਤੇ ਉਸ ਅੰਤ ਦੇਸ਼ ਦੀ ਸੁਰਖਤ ਅੰਕਨੀ ਅਕਾਲ ਟਿਕਾਣੀ ਦੇ ਨਾਮ ਬਣ ਦੇ ਸੁਕਾਮਲ ਦੇ ਪਹਿਚਾਨ ਦੁੱਖ ਜੈ। ਕੀਮਤ ਦੁੱਖ ਦੁੱਖ ਦੁੱਖ ਦੁੱਖ ਦੁੱਖ ਦੁੱਖ ਦੁੱਖ ਦੁੱਖ ਦੁੱਖ ਦੁੱਖ ਦੁੱਖ (844) 736-0920 ਤੇ ਬਰਾਤ ਬਰਾਤ।
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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 (844) 736-0920.

Serbian (Srpski): Ukoliko imate bilo kakvih pitanja u vezi sa ovim dokumentom, imate pravo da dobijete pomoć i informacije na vašem jeziku bez ikakvih troškova. Za razgovor sa prevodiocem, pozovite (844) 736-0920.

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Thai (ไทย): หากท่านมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร (844) 736-0920 เพื่อพูดคุยกับล่าม.

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