



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/>. 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) 333-5730 to request a copy.

| Important Questions                                                       | Answers                                                                                                                                                                                                                                                | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall <u>deductible</u>?</b>                             | \$750/person for In- <u>Network Providers</u> .                                                                                                                                                                                                        | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <b>plan</b> begins to pay. If you have other family members on the <b>plan</b> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .                                                                                                                                                               |
| <b>Are there services covered before you meet your <u>deductible</u>?</b> | Yes. Primary Care. <u>Specialist Visit</u> . <u>Preventive Care</u> . Certain <u>Prescription Drugs</u> . Vision Exam. For more information see below.                                                                                                 | This <b>plan</b> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <b>plan</b> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                            |
| <b>Are there other <u>deductibles</u> for specific services?</b>          | No.                                                                                                                                                                                                                                                    | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>What is the <u>out-of-pocket limit</u> for this <b>plan</b>?</b>       | \$3,500/person or \$7,000/family for In- <u>Network Providers</u> .                                                                                                                                                                                    | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <b>plan</b> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.                                                                                                                                                                                                                                                                                     |
| <b>What is not included in the <u>out-of-pocket limit</u>?</b>            | <u>Premiums</u> , <u>balance-billing</u> charges, and health care this <b>plan</b> doesn't cover.                                                                                                                                                      | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Will you pay less if you use a <u>network provider</u>?</b>            | Yes. See <a href="http://www.anthem.com/find-care/?alphaprefix=JMV">www.anthem.com/find-care/?alphaprefix=JMV</a> or call (855) 333-5730 for a list of <u>network providers</u> . Costs may vary by site of service and how the <u>provider</u> bills. | This <b>plan</b> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <b>plan's network</b> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <b>plan</b> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |

|                                                                  |      |                                                                                                                                                                                  |
|------------------------------------------------------------------|------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b> | Yes. | This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> . |
|------------------------------------------------------------------|------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

 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<br>(You will pay the least)                                                                                         | Non-Network Provider<br>(You will pay the most)                                                                            |                                                                                                                                                                                                                                                                                                                          |
| <b>If you visit a health care <u>provider's</u> office or clinic</b>                                                                                                                                                                               | Primary care visit to treat an injury or illness                 | \$25/visit, <u>deductible</u> does not apply                                                                                            | Not covered                                                                                                                | Virtual visits (Telehealth) benefits available.                                                                                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                    | <u>Specialist</u> visit                                          | \$40/visit, <u>deductible</u> does not apply                                                                                            | Not covered                                                                                                                | Virtual visits (Telehealth) benefits available.                                                                                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                    | <u>Preventive care</u> / <u>screening</u> /immunization          | No charge                                                                                                                               | Not covered                                                                                                                | You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.                                                                                                                                                  |
| <b>If you have a test</b>                                                                                                                                                                                                                          | <u>Diagnostic test</u> (x-ray, blood work)                       | No charge                                                                                                                               | Not covered                                                                                                                | -----none-----                                                                                                                                                                                                                                                                                                           |
|                                                                                                                                                                                                                                                    | Imaging (CT/PET scans, MRIs)                                     | 25% <u>coinsurance</u>                                                                                                                  | Not covered                                                                                                                | -----none-----                                                                                                                                                                                                                                                                                                           |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a> | Typically Lower Cost Generic (Tier 1a)                           | \$5/prescription, <u>deductible</u> does not apply (retail) and \$12.50/prescription, <u>deductible</u> does not apply (home delivery)  | 50% <u>coinsurance</u> up to \$250/prescription, <u>deductible</u> does not apply (retail) and Not covered (home delivery) | Most home delivery is 90-day supply. For more information, refer to “Essential Drug List” at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a><br><br>*See Prescription Drug section of the <u>plan</u> or policy document (e.g. evidence of coverage or certificate). |
|                                                                                                                                                                                                                                                    | Typically Generic (Tier 1b)                                      | \$15/prescription, <u>deductible</u> does not apply (retail) and \$37.50/prescription, <u>deductible</u> does not apply (home delivery) | 50% <u>coinsurance</u> up to \$250/prescription, <u>deductible</u> does not apply (retail) and Not covered (home delivery) |                                                                                                                                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                    | Typically Preferred Brand & Non-Preferred Generic Drugs (Tier 2) | \$40/prescription, <u>deductible</u> does not apply (retail) and \$120/prescription, <u>deductible</u> does not apply (home delivery)   | 50% <u>coinsurance</u> up to \$250/prescription, <u>deductible</u> does not apply (retail) and Not covered (home delivery) |                                                                                                                                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                    | Typically Non-Preferred Brand and Generic drugs (Tier 3)         | \$60/prescription, <u>deductible</u> does not apply (retail) and \$180/prescription, <u>deductible</u>                                  | 50% <u>coinsurance</u> up to \$250/prescription, <u>deductible</u> does not apply (retail) and Not covered (home delivery) |                                                                                                                                                                                                                                                                                                                          |

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

| Common Medical Event                                                      | Services You May Need                                             | What You Will Pay                                                                                            |                                                                                                                            | Limitations, Exceptions, & Other Important Information                                                                                                                |
|---------------------------------------------------------------------------|-------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                                   | In-Network Provider<br>(You will pay the least)                                                              | Non-Network Provider<br>(You will pay the most)                                                                            |                                                                                                                                                                       |
|                                                                           |                                                                   | does not apply (home delivery)                                                                               |                                                                                                                            |                                                                                                                                                                       |
|                                                                           | Typically Preferred <u>Specialty</u> (brand and generic) (Tier 4) | 30% <u>coinsurance</u> up to \$250/prescription, <u>deductible</u> does not apply (retail and home delivery) | 50% <u>coinsurance</u> up to \$250/prescription, <u>deductible</u> does not apply (retail) and Not covered (home delivery) |                                                                                                                                                                       |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center)                    | 25% <u>coinsurance</u>                                                                                       | Not covered                                                                                                                | -----none-----                                                                                                                                                        |
|                                                                           | Physician/surgeon fees                                            | No charge                                                                                                    | Not covered                                                                                                                | -----none-----                                                                                                                                                        |
| If you need immediate medical attention                                   | <u>Emergency room care</u>                                        | \$150/visit, then 25% <u>coinsurance</u>                                                                     | Covered as In- <u>Network</u>                                                                                              | <u>Copayment</u> waived if admitted. No charge for Emergency Room Physician Fee.                                                                                      |
|                                                                           | <u>Emergency medical transportation</u>                           | \$100/trip, <u>deductible</u> does not apply                                                                 | Covered as In- <u>Network</u>                                                                                              | -----none-----                                                                                                                                                        |
|                                                                           | <u>Urgent care</u>                                                | \$25/visit, <u>deductible</u> does not apply                                                                 | Covered as In- <u>Network</u>                                                                                              | -----none-----                                                                                                                                                        |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)                                | 25% <u>coinsurance</u>                                                                                       | Not covered                                                                                                                | 150 days/benefit period for Inpatient rehabilitation and skilled nursing services combined for In- <u>Network Providers</u> .                                         |
|                                                                           | Physician/surgeon fees                                            | No charge                                                                                                    | Not covered                                                                                                                | -----none-----                                                                                                                                                        |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                                               | Office Visit<br>\$25/visit, <u>deductible</u> does not apply<br>Other Outpatient<br>No charge                | Office Visit<br>Not covered<br>Other Outpatient<br>Not covered                                                             | Office Visit<br>988 lifeline/mobile crisis team covered as In- <u>Network</u> . Virtual visits (Telehealth) benefits available.<br>Other Outpatient<br>-----none----- |
|                                                                           | Inpatient services                                                | 25% <u>coinsurance</u>                                                                                       | Not covered                                                                                                                | No charge for Inpatient Physician Fee In- <u>Network Providers</u> . No Coverage for Inpatient Physician Fee Non- <u>Network Providers</u> .                          |
| If you are pregnant                                                       | Office visits                                                     | \$25/visit, <u>deductible</u> does not apply                                                                 | Not covered                                                                                                                | Maternity care may include tests and services described elsewhere                                                                                                     |

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

| Common Medical Event                                           | Services You May Need                     | What You Will Pay                                 |                                                 | Limitations, Exceptions, & Other Important Information                                                                        |
|----------------------------------------------------------------|-------------------------------------------|---------------------------------------------------|-------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                           | In-Network Provider<br>(You will pay the least)   | Non-Network Provider<br>(You will pay the most) |                                                                                                                               |
|                                                                | Childbirth/delivery professional services | No charge                                         | Not covered                                     | in the SBC (i.e., ultrasound).<br>*Coverage includes fertility preservation services, see Fertility Preservation section.     |
|                                                                | Childbirth/delivery facility services     | 25% <u>coinsurance</u>                            | Not covered                                     |                                                                                                                               |
| If you need help recovering or have other special health needs | <u>Home health care</u>                   | \$25/visit <u>deductible</u> does not apply       | Not covered                                     | 100 visits/benefit period for In- <u>Network Providers</u> .                                                                  |
|                                                                | <u>Rehabilitation services</u>            | \$25/visit <u>deductible</u> does not apply       | Not covered                                     | *See Therapy Services section.                                                                                                |
|                                                                | <u>Habilitation services</u>              | \$25/visit <u>deductible</u> does not apply       | Not covered                                     |                                                                                                                               |
|                                                                | <u>Skilled nursing care</u>               | 25% <u>coinsurance</u>                            | Not covered                                     | 150 days/benefit period for Inpatient rehabilitation and skilled nursing services combined for In- <u>Network Providers</u> . |
|                                                                | <u>Durable medical equipment</u>          | 50% <u>coinsurance, deductible</u> does not apply | Not covered                                     | *See <u>Durable Medical Equipment</u> Section                                                                                 |
|                                                                | <u>Hospice services</u>                   | No charge                                         | Not covered                                     | -----none-----                                                                                                                |
| If your child needs dental or eye care                         | Children's eye exam                       | No charge                                         | Not covered                                     | *See Vision Services section                                                                                                  |
|                                                                | Children's glasses                        | Not covered                                       | Not covered                                     |                                                                                                                               |
|                                                                | Children's dental check-up                | Not covered                                       | Not covered                                     | -----none-----                                                                                                                |

### Excluded Services & Other Covered Services:

| Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other excluded services.)  |                                                                                                                                                      |                                                                                                                                                                              |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <ul style="list-style-type: none"> <li>Children's dental check-up</li> <li>Glasses for a child</li> <li>Long-term care</li> <li>Weight loss programs</li> </ul> | <ul style="list-style-type: none"> <li>Cosmetic surgery</li> <li>Hearing aids</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>Dental care (Adult)</li> <li>Infertility treatment</li> <li>Routine foot care unless you have been diagnosed with diabetes</li> </ul> |  |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)                             |                                                                                                                                                      |                                                                                                                                                                              |  |
| <ul style="list-style-type: none"> <li>Acupuncture 20 visits/benefit period</li> <li>Private-duty nursing in a Home Setting only</li> </ul>                     | <ul style="list-style-type: none"> <li>Bariatric surgery</li> </ul>                                                                                  | <ul style="list-style-type: none"> <li>Chiropractic care 20 visits/benefit period</li> </ul>                                                                                 |  |

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

- Routine eye care (Adult) 1 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 Managed Health Care, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725, (888) 466-2219, <https://www.dmhca.ca.gov/>, Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or contact Anthem at the number on the back of your ID card. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information 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

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

Department of Managed Health Care, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725, (888) 466-2219, <https://www.dmhca.ca.gov/>

California Consumer Assistance Program, Operated by the California Department of Managed Health Care, 980 9th St, Suite #500, Sacramento, CA 95814, (888) 466-2219, <https://www.dmhca.ca.gov/>

**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.*

## 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 <u>plan's</u> overall <u>deductible</u> | \$750 |
| ■ <u>Specialist copayment</u>                 | \$40  |
| ■ Hospital (facility) <u>coinsurance</u>      | 25%   |
| ■ Other <u>coinsurance</u>                    | 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:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$750          |
| <u>Copayments</u>                 | \$40           |
| <u>Coinsurance</u>                | \$1,600        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$2,450</b> |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                               |       |
|-----------------------------------------------|-------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$750 |
| ■ <u>Specialist copayment</u>                 | \$40  |
| ■ Hospital (facility) <u>coinsurance</u>      | 25%   |
| ■ Other <u>coinsurance</u>                    | 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:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$0            |
| <u>Copayments</u>                 | \$1,500        |
| <u>Coinsurance</u>                | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,520</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|                                               |       |
|-----------------------------------------------|-------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$750 |
| ■ <u>Specialist copayment</u>                 | \$40  |
| ■ Hospital (facility) <u>coinsurance</u>      | 25%   |
| ■ Other <u>coinsurance</u>                    | 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:

| <u>Cost Sharing</u>               |              |
|-----------------------------------|--------------|
| <u>Deductibles</u>                | \$400        |
| <u>Copayments</u>                 | \$400        |
| <u>Coinsurance</u>                | \$100        |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$900</b> |

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):** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር 1-888-254-2721 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 1-888-254-2721.

**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՝ 1-888-254-2721:

**Bassa (Bàsɔ̀ Wùdù):** M̈ dyi dyi-diè-djé b̈é b̈édjé b̈á céè-djé nià k̈e dyí ní, ɔ m̈ò ni dyí-b̈édjé-in-djé b̈é m̈ k̈é gbo-kpá-kpá k̈é b̈ɔ́ kpɔ́ djé m̈ bídjí-wùdùùn b̈ó pídyi. B̈é m̈ k̈é wuɖu-zìin-nyò d̈ò gbo wùdù k̈e, d̈á 1-888-254-2721.

**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 1-888-254-2721 -তে কল করুন।

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖု 1-888-254-2721 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1-888-254-2721。

**Dinka (Dinka):** Na nōŋ thiëc në ke de yā thorë, ke yin nōŋ loŋ bē yi kuony ku wër alëu bē gëer yic yin ne thoŋ du ke cin wëu tāäuë ke piny. Te kōr yin ba jam wënë ran ye thok geryic, ke yin cōl 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.

**Farsi (فارسي):** در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره 1-888-254-2721 تماس بگیرید.

## 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 પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો 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.

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**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 1-888-254-2721.

**Igbo (Igbo):** O bụrụ na ị nwere ajuju o bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ugwo o bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ 1-888-254-2721.

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## Language Access Services:

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**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.

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ເພື່ອໂອ້ນລັກກັບລາມແປພາສາ, ໃຫ້ໂທຫາ 1-888-254-2721.

**Navajo (Diné):** Díí naaltsoos biká'ígíí łahgo bina'ídiłkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee níl hodoonih t'áadoo bááh ilínígóó. Ata' halne'ígíí lá' bich'í' hadeesdzih nínízingo kojí' hodiłnih 1-888-254-2721.

**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 1-888-254-2721

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

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## Language Access Services:

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