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. 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 (800) 843-5621 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>Combined in- and out-of-network: $1,000/individual or $2,000/family aggregate.</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. Preventive care</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>Yes. A separate $150 individual deductible and $300 family deductible for prescriptions</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>Combined in- and out-of-network: Medical $5,000/individual or $10,000/family aggregate. Prescription Drug $1,000/individual or $2,000/family aggregate.</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>Deductibles, Pre-Authorization Penalties, 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, PPO. See <a href="http://www.anthem.com">www.anthem.com</a> or call (800) 843-5621 for a list of network providers.</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 referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</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>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 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>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Preventive care/ screening/ immunization</td>
<td>No charge</td>
<td>20% coinsurance not subject to deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>For coverage for colonoscopies with a medical diagnosis, see Outpatient Surgery benefit.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></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>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>Lab – Office</td>
<td>Lab – Office</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>X-Ray – Office</td>
<td>X-Ray – Office</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Costs may vary by site of service. X-Ray – Office</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Costs may vary by site of service.</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1 - Typically Generic</td>
<td>20% coinsurance after separate deductible for retail or specialty prescription drugs of $150 per member or $300 per family</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Retail includes a 34-90 day supply; Mail order includes a 90-day supply. Outpatient retail and specialty prescription drugs have a separate out-of-pocket annual maximum of $1,000 per member or $2,000 per family. Precertification may be required for certain Prescription Drugs. Please note that certain Specialty Drugs are only available from the Specialty Pharmacy and you will not be able to get them at a Retail Pharmacy or through the Home Delivery (Mail Order) Pharmacy. *See Prescription Drug Section of your evidence of coverage, available in the footnote below.</td>
</tr>
<tr>
<td></td>
<td>Tier 2 - Typically Preferred / Brand</td>
<td>20% coinsurance after separate deductible for retail or specialty prescription drugs of $150 per member or $300 per family</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Tier 3 - Typically Non-Preferred / Specialty Drugs</td>
<td>20% coinsurance after separate deductible for retail or specialty prescription drugs of $150 per member or $300 per family</td>
<td>Not covered</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).
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</thead>
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<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 outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physicin/surgeon fees</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>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% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>20% 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% coinsurance Other Outpatient 20% coinsurance</td>
<td>Office Visit Other Outpatient</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>20% coinsurance</td>
<td>20% 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>
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</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>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>100 day limit/benefit period in- and out-of-network combined.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>---------none---------</td>
</tr>
<tr>
<td>Hospice services</td>
<td>No charge</td>
<td>No charge</td>
<td>---------none---------</td>
</tr>
</tbody>
</table>

**If you need dental or eye care**

<table>
<thead>
<tr>
<th></th>
<th></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>Eye exam</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>Limited to one exam per calendar year, per member.</td>
</tr>
<tr>
<td>Glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>---------none---------</td>
</tr>
<tr>
<td>Dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>---------none---------</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
- Long-term care
- Dental care (adult)
- Preauthorization - You may have to pay for all or a portion of any test, equipment, service or procedure that is not preauthorized. To find out which services require Preauthorization and to be sure that Preauthorization has been given, you may contact us.
- Weight loss programs
- Infertility treatment
- Private-duty nursing
- Routine foot care unless you have been diagnosed with diabetes.
- Bariatric surgery
- Most coverage provided outside the United States. See www.bcbsglobalcore.com
- Chiropractic care (limits apply)
- Hearing aids (Limits apply)

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

- Bariatric surgery
- Most coverage provided outside the United States. See www.bcbsglobalcore.com
- Chiropractic care (limits apply)
- Hearing aids (Limits apply)

**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: Division of Insurance, ICARE Section, 1560 Broadway, Suite 850, Denver, Colorado 80202, (303) 894-7490. Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

* For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/eocdps/aso.
Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

ATTN: Grievances and Appeals, 700 Broadway, Mail Stop CO0104-0430, Denver, CO 80273

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

Division of Insurance, ICARE Section, 1560 Broadway, Suite 850, Denver, Colorado 80202, (303) 894-7490

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 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.
The plan would be responsible for the other costs of these EXAMPLE covered services.

### About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

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

- **The plan's overall deductible**: $1,000
- **Specialist copayment**: 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**: $12,840

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductibles</strong></td>
<td>$1,000</td>
</tr>
<tr>
<td><strong>Copayments</strong></td>
<td>$0</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>$2,368</td>
</tr>
<tr>
<td>What isn't covered</td>
<td>$60</td>
</tr>
</tbody>
</table>

The total Peg would pay is **$3,428**

---

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

- **The plan's overall deductible**: $1,000
- **Specialist copayment**: 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**: $7,460

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductibles</strong></td>
<td>$1,000</td>
</tr>
<tr>
<td><strong>Copayments</strong></td>
<td>$0</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>$1,292</td>
</tr>
<tr>
<td>What isn't covered</td>
<td>$55</td>
</tr>
</tbody>
</table>

The total Joe would pay is **$2,347**

---

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

- **The plan's overall deductible**: $1,000
- **Specialist copayment**: 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**: $2,010

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductibles</strong></td>
<td>$1,000</td>
</tr>
<tr>
<td><strong>Copayments</strong></td>
<td>$0</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>$202</td>
</tr>
<tr>
<td>What isn't covered</td>
<td>$0</td>
</tr>
</tbody>
</table>

The total Mia would pay is **$1,202**

---

The plan would be responsible for the other costs of these EXAMPLE covered services.
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 (800) 843-5621

Amharic (አማርኛ):ARIABLE 8200 843 5621: (800) 843 5621.

Armenian (հայերեն): Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունքում ունեք անվճար ստանալ օգնություն և տեղեկատվություն: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (800) 843-5621:

Basa (Bässo Wùqì): M dyi dyi-die-dê bê béde bâ céê-dê nià ke dyî ni, o mô ni dyi-bêdeín-dê bê m ke gbo-kpá-kpá kê bô kpô dé m bidí-wùqùn bô pîdyi. Bê m ke wuçu-zin-nyo gbo wùqû ke, qá (800) 843-5621.

Bengali (বাংলা): যদি এই লিখিতের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষার বিলাসুল্লভ সাহায্য পাওয়ার ও অথবা পাওয়ার অধিকার আপনার আছে। একজন দোকানীর সাথে কথা ঝাড় জল্প (800) 843-5621।

Burmese (မြန်မာ): သင်မှာ မဟုတ်ဘဲ သင်အောက်ခံပါလိမ့်မယ်။ အခေါ်အမှန် မိမိန်းကို ရှင်းလင်းပါ။ (800) 843-5621

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 (800) 843-5621。

Dinka (Dinka): Na nga thiicce nê ke de yâ thöre, ke yin nga loj be yi kuony ku wer aleu be geer yic yin ne thon du ke cin wëu tàâe ke pîny. Te ko yin ba jam wënh ren ye thok gercy, ke yin col (800) 843-5621.

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 (800) 843-5621.

Farsi (فارسی): در صورتی که سؤالی پیرامون این سند داردی، این حق را داردی که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادریتان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره 843-5621 تماس بگیرید.

French (Français): Si vous avez des questions sur ce document, vous avez la possibilité d’accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (800) 843-5621.
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 (800) 843-5621.

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 διερμηνεύ, ηλεκτροφωνήστε στο (800) 843-5621.

Gujarati (ગુજરાતી): તમે ડકમ્યુન્ટ સાથે કોઈ પ્રશ્ન હોઈ શકે તો, આ વ્યું એ વિષયની માહિતીને મેળવવા માટે એક વિદ્વાન કાન્નેગની તમામ બદલાઓ માટે આપણે વેપાર કરી રહ્યાં છીએ. તમામ વિશાળ સાથે વાત કરવા માટે, (800) 843-5621 ટવલ કરો.

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 (800) 843-5621.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज के बारे में कोई प्रश्न है, तो आपको नि:शुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। तुराप्सिय देखे बात करने के लिए, कॉल करें (800) 843-5621।

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 (800) 843-5621.

Igbo (Igbo): O bụrụ na i nwere ajụjụ o bula ụgbasa akwụkwọ a, i nwere ikiye ịnwe enyemaka na ọzi n'asụsụ gi na akwụghị ụgwọ o bula. Ka gi na ọkwọ okwu kwuo okwu, kpọọ (800) 843-5621.

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 (800) 843-5621.

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 (800) 843-5621.

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 (800) 843-5621.

Japanese (日本語): この文書についてなにか不十分な点があれば、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、(800) 843-5621 にお電話ください。
Khmer (ខ្មែរ): ប្រសិនបើអ្នកមានសេចក្តីសុំអំពីការអាននេះ អ្នកអាចសុំឱ្យមកឃើញពន្លឺមកព្រ័ត្នដៃពិភាក្សាដោយរៀនរៀង។ អ្នកអាចចូលទៅក្នុងប្រព័ន្ធការអាននេះ (800) 843-5621 ។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (800) 843-5621.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (800) 843-5621 로 문의하십시오.

Lao (ພາສາລາວ): ຄົ້ນຄ້ານມີຄ່າງກໍ່າງໃນການແຫລ່ງຂ້າງແຕ່ລະການນີ້, ຜົນນຳທັງໝັດກ່ອຍຄວນ້າທ້າຍທັງໝັດ ແລະ ທ້າຍມີພາສາທະນາຄູ້ງານໃນອະນັຍການຂອງທ້າຍໆ. ໃຊ້ໝວດນັ້ນໄດ້ນາມສະແດງຂ້າງແຕ່ລະການ (800) 843-5621.

Navajo (Diné): Díí naaltsos bika’íí gí: bi na bohónéédzí dóó bee ahóót’ii t’áá ni nízaad k’éhí bee nił hodooñih t’áadoo bááh’ílinigóó. Atá’ halne’íí gí: la’ bieh’í’ hadéesdzíh níniñiño koj’í hodíílínih (800) 843-5621.

Nepali (नेपाली): नेपाली भाषायाँमध्ये उपार्जित केही प्रश्न हुए भने, आपले भाषासः विश्लेषक उपार्जित तथा जानकारी प्राप्त गर्न पाउने लाग्छ सहकारी हो। दोमाधारण कुरा गर्नका लागि, यहाँ कल गन्य (800) 843-5621

Oromo (Oromifaa): Sanadi kanaa wajiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuuf mirgaa qabdaa. Turjumaana dubaachuuf, (800) 843-5621 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 (800) 843-5621.

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 (800) 843-5621.

Punjabi (ਪੰਜਾਬੀ): ਹੱਦੁੰਦੇ ਇਸ ਦокумент ਵਿਚ ਵੀਡੀਓ ਸਮਾਚਾਰ ਹੋਵੇ ਤਾਂ ਹੱਦੁੰਦੇ ਵੀਡੀਓ ਸਮਾਚਾਰ ਵਿਚ ਆਪਣੀ ਸੰਨੋਤੀ ਸੀਮਾ ਹੋਵੇ ਅਤੇ ਅਧਿਐਨ ਹੋਵੇ। ਇਨਾਂ ਸਮਾਚਾਰਾਂ ਦੀਆਂ ਸੰਨੋਤੀ ਸੀਮਾ ਚਲਣ ਲਈ (800) 843-5621 ਲਗਾਓ।
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