### Summary of Benefits and Coverage

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://ecom.anthem.com/eocdps/aso](https://ecom.anthem.com/eocdps/aso). For general definitions of common terms, such as **allowed amount**, **balance billing**, **coinsurance**, **copayment**, **deductible**, **provider**, or other **underlined** terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](https://www.healthcare.gov/sbc-glossary/) or call (855) 502-6365 to request a copy.

#### Important Questions

<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>$2,500/individual or $5,000/family for In-Network Providers, $5,000/individual or $10,000/family for Out-of-Network Providers.</td>
<td>Generally, you must pay all of the costs from <strong>providers</strong> up to the <strong>deductible</strong> amount before this <strong>plan</strong> begins to pay. If you have other family members on the policy, the overall family <strong>deductible</strong> must be met before the <strong>plan</strong> begins to pay. Out-of-Network Providers. In-Network Providers and Non-Network Providers deductibles are separate and do not count towards each other.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. <strong>Preventive care</strong> for In-Network Providers.</td>
<td>This <strong>plan</strong> covers some items and services even if you haven’t yet met the <strong>deductible</strong> amount. But a <strong>copayment</strong> or <strong>coinsurance</strong> may apply. For example, this <strong>plan</strong> covers certain preventive services without <strong>cost-sharing</strong> and before you meet your <strong>deductible</strong>. 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 <strong>deductibles</strong> for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>$5,000/individual or $7,350/individual on a family or $10,000/family for In-Network Providers, $10,000/individual or $20,000/family for Out-of-Network Providers.</td>
<td>The <strong>out-of-pocket limit</strong> is the most you could pay in a year for covered services. If you have other family members in this <strong>plan</strong>, they have to meet their own <strong>out-of-pocket limits</strong> until the overall family <strong>out-of-pocket limit</strong> has been met. Out-of-Network Providers. In-Network Providers and Non-Network Providers Out of Pocket are separate and do not count towards each other.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Services deemed not medically necessary by Medical Management and/or Anthem, Penalties for non-compliance, <strong>Premiums</strong>, <strong>balance-billing</strong> charges, and health care this <strong>plan</strong> doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the <strong>out-of-pocket limit</strong>.</td>
</tr>
</tbody>
</table>

IN/L/A/PurdUniHlthPlaPlusHSA2-CDHP-NA/NA-NA/AWQ0U/NA/01-18
**Will you pay less if you use a network provider?**

Yes, Blue Card PPO. See [www.anthem.com](http://www.anthem.com) or call (855) 502-6365 for a list of network providers.

This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

**Do you need a referral to see a specialist?**

No.

You can see the specialist you choose without a referral.

---

**All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.**

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<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>25% coinsurance</td>
<td>45% coinsurance</td>
<td>$40 flat fee for Center for Healthy Living.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>25% coinsurance</td>
<td>45% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>45% coinsurance</td>
<td>Hearing exam (routine) and Vision exam (routine): Not covered. 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>25% coinsurance</td>
<td>45% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>25% coinsurance</td>
<td>45% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Preventive Generic Drugs</td>
<td>Retail and Home Delivery: Covered in Full</td>
<td>Retail and Home Delivery: Covered in Full</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Generic Drugs</td>
<td>Retail: Actual cost up to $10 max/Home</td>
<td>Retail: Actual cost up to $10 max/Home</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preferred Brand Drugs</td>
<td>Retail: 35% coinsurance/Home Delivery: 25% coinsurance</td>
<td>Retail: 35% coinsurance/Home Delivery: 25% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Brand Drugs</td>
<td>Retail: 55% coinsurance/Home Delivery: 45% coinsurance</td>
<td>Retail: 55% coinsurance/Home Delivery: 45% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>25% coinsurance</td>
<td>45% coinsurance</td>
<td></td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see plan or policy document at [https://eoc.anthem.com/eocdps/aso](https://eoc.anthem.com/eocdps/aso).
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Physician/surgeon fees</td>
<td>25% coinsurance</td>
<td>45% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Emergency room care</td>
<td>25% coinsurance</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>25% coinsurance</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>25% coinsurance</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>25% coinsurance</td>
<td>45% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>25% coinsurance</td>
<td>45% coinsurance</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office Visit 25% coinsurance</td>
<td>Office Visit 45% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other Outpatient 25% coinsurance</td>
<td>Other Outpatient 45% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>25% coinsurance</td>
<td>45% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>25% coinsurance</td>
<td>45% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>25% coinsurance</td>
<td>45% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>25% coinsurance</td>
<td>45% coinsurance</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>25% coinsurance</td>
<td>45% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>25% coinsurance</td>
<td>45% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>25% coinsurance</td>
<td>45% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>25% coinsurance</td>
<td>45% coinsurance</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durable medical equipment</td>
<td>25% coinsurance</td>
<td>25% coinsurance</td>
<td>combined is limited to 120 days limit per benefit period.</td>
</tr>
<tr>
<td>Hospice services</td>
<td>25% coinsurance</td>
<td>45% coinsurance</td>
<td>Pre-certification may be required.</td>
</tr>
</tbody>
</table>

#### If your child needs dental or eye care

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s eye exam</td>
<td>25% coinsurance</td>
<td>45% coinsurance</td>
<td>Pre-certification may be required.</td>
</tr>
<tr>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Pre-certification may be required.</td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Pre-certification may be required.</td>
</tr>
</tbody>
</table>

#### Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover**

- Abortion
- Dental care (adult)
- Long-term care
- Acupuncture
- Hearing aids
- Routine foot care unless you have been diagnosed with diabetes.
- Cosmetic surgery
- Infertility treatment
- Weight loss programs

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

- Bariatric surgery (only for morbid obesity)
- Chiropractic care 26 visits/benefit period.
- Most coverage provided outside the United States. See [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)
- Private-duty nursing only covered in the home
  - 120 visits/benefit period including home health care.
- 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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, [www.cciio.cms.gov](http://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](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

* 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).
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, P.O. Box 105568, Atlanta GA 30348-5568


**Does this plan provide Minimum Essential Coverage? Yes**

If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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.

---

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

- The plan’s overall deductible: $2,500
- Specialist coinsurance: 25%
- Hospital (facility) coinsurance: 25%
- Other coinsurance: 25%

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

- The plan’s overall deductible: $2,500
- Specialist coinsurance: 25%
- Hospital (facility) coinsurance: 25%
- Other coinsurance: 25%

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

- The plan’s overall deductible: $2,500
- Specialist coinsurance: 25%
- Hospital (facility) coinsurance: 25%
- Other coinsurance: 25%

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></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$2,500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,500</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $96

The total Peg would pay is

$5,096

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></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$899</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$300</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $6,041

The total Joe would pay is

$7,240

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></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,444</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$481</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $0

The total Mia would pay is

$1,925

---

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 përshkryer, telefononi (855) 502-6365

Amharic (አማርኛ):- ለሰላው መርም ያቀረበ እየተወሰኝ ከመርም ያሆኑት, ከም ይሆኝ ለእምነት ከም ለእምነት ያስቀርበት ከህግ መቅረብ ለማስቀር ከሚያስቀር ከማስቀር ከሚያስቀር ከማስቀር ከሚያስቀር ከሚያስቀር ከሚያስቀር ከሚያስቀር ከሚያስቀር ከሚያስቀር ከሚያስቀር ከሚያስቀር ከሚያስቀር ከሚያስ麒麟 ከሚያስ麒麟 ከሚያስ麒麟 ከሚያስ麒麟 ከሚያስ麒麟 ከሚያስ麒麟 ከሚያስ麒麟 ከሚያስ麒麟 ከሚያስ麒 (855) 502-6365 ይደውሉ።

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՝ (855) 502-6365:


Bengali (বাংলা): যদি এই নথিগুলির বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিশ্বাসযুক্ত সহায়তা পাওয়ার ও ভাষা পাওয়ার অধিকার আপনার আছে। একজন পেশাদারীর সাথে কথা বলার জন্য (855) 502-6365 -তে কল করুন।

Burmese (မြန်မာ): တိုက်ခိုက်သော မြန်မာလိုက် အချက်အလက်များကို ဖျင်သွင်းရန် အခြေခံသော မီးမှာ ဖြစ်ပါတယ်။ အညီအကြားရန် အခြေခံသော မီးကို (855) 502-6365 ထွက်ပြောပါသည်။

Chinese (中文)：如果您对本文件有任何疑问，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 (855) 502-6365。

Dinka (Dinka): Na nąg thièée nè ke de yá thoré, ke yin nąg loñ bë yi kuony ku wer aleu bê geér yi yin ne thon du ke cin wèu tăâuè ke pìny. Te kôr yin ba jamb wènè ran ye thok geuyic, ke yin col (855) 502-6365.

Dutch (Nederlands): Bij vragen over dit document heb je recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (855) 502-6365.

Farsi (فارسی): در صورتی که سوالی بپرسید این سند داده، این حق را دارید که اطلاعاتی را که نیاز دارید بدون هیچ هزینه ای به زبان مادریتان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره ۶۳۵۰۲-۶۳۶۵ 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 (855) 502-6365.
Language Access Services:

**German (Deutsch):** Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (855) 502-6365.

**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 (855) 502-6365.

**Gujarati (ગુજરાતી):** જો આ દસ્તાવેજ અને આપને કોઈ પણ પ્રશ્ન હોય તો, કોઈપણ બદલ આપની ભાષામાં મદદ અને માહિતી મળવાનો તમને અધિકાર છે. ટૂબ્યુલિયા સાથે વાત કરવા માટે, કોલ કરો (855) 502-6365.

**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 (855) 502-6365.

**Hindi (हिन्दी):** अगर आपके पास इस दस्तावेज के बारे में कोई प्रश्न हैं, तो आपको निष्कृत अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुमापिये से बात करने के लिए, कॉल करें (855) 502-6365.

**Hmong (White Hmong):** Yog tias koj muaj lus nug dab tsi ntsig txog daim ntavv 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 (855) 502-6365.

**Igbo (Igbo):** Ọ bụrụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ ị na akwụgbu ngwọ ọ bụla. Ka ị ọ gọ ọkwọ okwu kwuo okwu, kpọọ (855) 502-6365.

**Ilokano (Ilokano):** Nu addaan ka iti ani man a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impomasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (855) 502-6365.

**Indonesian (Bahasa Indonesia):** Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (855) 502-6365.

**Italian (Italiano):** In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (855) 502-6365.

**Japanese (日本語):** この文書についてな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、(855) 502-6365 にお電話ください。
Language Access Services:

**Khmer (ភាសាខ្មែរ):** ប្រការការងារការសម្រួលប្រការនៃការងារ: ប្រការការងារប្រការប្រការនៃការងារប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រការប្រ�较长
Language Access Services:

Romanian (Română): Dacă aveți întrebări referitoare la acest document, aveți dreptul să primiți ajutor și informații în limba dumneavoastră în mod gratuit. Pentru a vă adresa unui interpreter, contactați telefonic (855) 502-6365.

Russian (Русский): Если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (855) 502-6365.

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 (855) 502-6365.


Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (855) 502-6365.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (855) 502-6365.

Thai (ไทย): หากท่านมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร (855) 502-6365 เพื่อพบผู้ช่วยสนับสนุน

Ukrainian (Українська): Якщо у вас виникають запитання з приводу цього документу, ви маєте право безкоштовно отримати допомогу й інформацію вашою рідною мовою. Щоб отримати послуги перекладача, звертайтеся за номером (855) 502-6365.

Urdu (اردو): اگر اس دستاویز کے بارے میں آپ کا کوئی سوال ہے، آپ کو مدد اور اپنی زبان میں مفت معلومات حاصل کرنا کا احق حاصل ہے۔ آپ مترجوم سے بات کر سکتے ہیں۔ (855) 502-6365.

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thống dịch viên, hãy gọi (855) 502-6365.

Yiddish (אידיש): המהאר את השאלות והשאלות של המבוקש, שאינן ידועות בברוקóc דאואם,anning. לאира די רעטן זא ברוקוכס דאואם איינפראמאיטיז'אי ראש שפערטך אען קלי. זא רעטן זא (855) 502-6365.

Yoruba (Yorùbá): Ti o bá ní èyíkéyà ìbìrè nípa àkòsèlè yìí, o ní ètò jári gba ìrànàwó àti ìwìfü àti èdè rẹ̀ lọ́fèè. Bá wa ògbùfù kan sọ̀rù, pe (855) 502-6365.
Language Access Services:

It’s important we treat you fairly

That’s why we follow federal civil rights laws in our health programs and activities. We don’t discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn’t English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.