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/ca/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 (833) 674-9256 to request a copy.

### Important Questions

<table>
<thead>
<tr>
<th><strong>What is the overall deductible?</strong></th>
<th><strong>Answers</strong></th>
<th><strong>Why This Matters:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>$0/person or $0/family for Preferred Network Providers.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
<td></td>
</tr>
<tr>
<td>$100/person or $200/family for In-Network Providers.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$200/person or $500/family for Non-Network Providers.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **Are there services covered before you meet your deductible?** | Yes. Preventive Care, Primary Care, Specialist Visit for In-Network and Non-Network Providers, Tier 1 Tier 2 Tier 3 and Tier 4 Prescription Drugs for In-Network and Non-Network Providers. | 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 https://www.healthcare.gov/coverage/preventive-care-benefits/. |

| **Are there other deductibles for specific services?** | No. | You don’t have to meet deductibles for specific services. |

| **What is the out-of-pocket limit for this plan?** | $1,000/person or $2,000/family for Preferred Network Providers and In-Network Providers combined. $2,000/person or $4,000/family for Non-Network Providers. | 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. |

| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges, and health care this plan doesn’t cover. | Even though you pay these expenses, they don’t count toward the out-of-pocket limit. |

| **Will you pay less if you use a network** | Yes, Prudent Buyer PPO. See www.anthem.com/ca or | You pay the least if you use a provider in Preferred Network. You pay more if you use a provider in In-Network. You will pay the most if you use an Out-of-Network Provider, and |
**provider?**  
call (833) 674-9256 for a list of **network providers**.

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.

<table>
<thead>
<tr>
<th>Do you need a <strong>referral</strong> to see a <strong>specialist</strong>?</th>
<th>No.</th>
<th>You can see the <strong>specialist</strong> you choose without a <strong>referral</strong>.</th>
</tr>
</thead>
</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>Preferred Network Provider (You will pay the least)</th>
<th>In-Network Provider (You will pay more)</th>
<th>Non-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 <strong>provider’s</strong> office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$15/visit</td>
<td>$15/visit <strong>deductible</strong> does not apply</td>
<td>30% <strong>coinsurance</strong></td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$15/visit</td>
<td>$15/visit <strong>deductible</strong> does not apply</td>
<td>30% <strong>coinsurance</strong></td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Preventive care/ screening/ immunization</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
<td><strong>You may have to pay for services that aren’t preventive. Ask your <strong>provider</strong> if the services needed are preventive. Then check what your <strong>plan</strong> will pay for.</strong></td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
<td>10% <strong>coinsurance</strong></td>
<td>30% <strong>coinsurance</strong></td>
<td><strong>Cost may vary by site of service.</strong></td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No charge</td>
<td>10% <strong>coinsurance</strong></td>
<td>30% <strong>coinsurance</strong></td>
<td><strong>Cost may vary by site of service.</strong></td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1 - Generic</td>
<td>$10/prescription, (retail and home delivery)</td>
<td>$10/prescription, <strong>deductible</strong> does not apply (retail and home delivery)</td>
<td>50% <strong>coinsurance</strong> up to $250/prescription <strong>deductible</strong> does not apply (retail and home delivery)</td>
<td>*<em>Most home delivery is 90-day supply. <em>See Prescription Drug section of the <strong>plan</strong> or policy document (e.g. evidence of coverage or certificate).</em></em></td>
</tr>
<tr>
<td>More information about <strong>prescription drug coverage</strong> is available at <a href="http://www.anthe">http://www.anthe</a></td>
<td>Tier 2 - Brand Formulary</td>
<td>$20/prescription, (retail) and <strong>deductible</strong> does</td>
<td>$20/prescription, <strong>deductible</strong> does</td>
<td>50% <strong>coinsurance</strong> up to $250/</td>
<td>*<em>Most home delivery is 90-day supply. <em>See Prescription Drug section of the <strong>plan</strong> or policy document (e.g. evidence of coverage or certificate).</em></em></td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see **plan** or policy document at [https://eoc.anthem.com/eocdps/ca/aso](https://eoc.anthem.com/eocdps/ca/aso).
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Preferred Network Provider (You will pay the least)</th>
<th>In-Network Provider (You will pay more)</th>
<th>Non-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>m.com/pharmacyinformation/ National Drug List</td>
<td></td>
<td>$30/prescription, (home delivery)</td>
<td>not apply (retail) and $30/prescription, deductible does not apply (home delivery)</td>
<td>prescription, deductible does not apply (retail) and Not covered (home delivery)</td>
<td></td>
</tr>
<tr>
<td>Tier 3 - Brand Non-Formulary</td>
<td>$40/prescription, (retail) and $50/prescription (home delivery)</td>
<td>$40/prescription, deductible does not apply (retail) and $50/prescription, deductible does not apply (home delivery)</td>
<td>50% coinsurance up to $250/ prescription, deductible does not apply (retail) and Not covered (home delivery)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 4 - Specialty Drugs</td>
<td>$40/prescription, (retail) and $50/prescription (home delivery)</td>
<td>$40/prescription, deductible does not apply (retail) and $50/prescription, deductible does not apply (home delivery)</td>
<td>50% coinsurance up to $250/ prescription, deductible does not apply (retail) and Not covered (home delivery)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>No charge</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>$350 maximum benefit/service for Non-Network Providers.</td>
<td></td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>---none---</td>
<td></td>
</tr>
<tr>
<td>Emergency room care</td>
<td>No charge</td>
<td>$100/visit deductible does not apply</td>
<td>Covered as In-Network</td>
<td>---none---</td>
<td></td>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td>Not Applicable</td>
<td>10% coinsurance</td>
<td>Covered as In-Network</td>
<td>---none---</td>
<td></td>
</tr>
<tr>
<td>Urgent care</td>
<td>$15/visit deductible does not apply</td>
<td>30% coinsurance</td>
<td>---none---</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/eocdps/ca/aso.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Preferred Network Provider (You will pay the least)</th>
<th>In-Network Provider (You will pay more)</th>
<th>Non-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$250/admission</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>$600 maximum benefit/day for Non-Emergency Admissions to Non-Network Providers.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>--------none--------</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office Visit $15/visit Other Outpatient No charge</td>
<td>Office Visit $15/visit deductible does not apply Other Outpatient 10% coinsurance</td>
<td>Office Visit 30% coinsurance Other Outpatient 30% coinsurance</td>
<td>Office Visit --------none-------- Other Outpatient --------none--------</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>$250/admission</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>$600 maximum benefit/day for Non-Emergency Admissions to Non-Network Providers.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>$15/visit</td>
<td>$15/visit deductible does not apply</td>
<td>30% coinsurance</td>
<td>$600 maximum benefit/day for Non-Emergency Admissions to Non-Network Providers. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>--------none--------</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$250/admission</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>--------none--------</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>Not Applicable</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>100 visits/benefit period.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$15/visit</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>*See Therapy Services section.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$15/visit</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>100 days/benefit period for skilled nursing services.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>Not Applicable</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>*See Durable Medical Equipment Section</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>Not Applicable</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>*See Durable Medical Equipment Section</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>Not Applicable</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>--------none--------</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>--------none--------</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>--------none--------</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>--------none--------</td>
</tr>
</tbody>
</table>

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

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

- Cosmetic surgery
- Dental Check-up
- Infertility treatment
- Routine foot care unless you have been diagnosed with diabetes
- Dental care (Adult)
- Eye exams for a child
- Long-term care
- Weight loss programs
- Dental care (Pediatric)
- Glasses for a child
- Routine eye care (Adult)

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

- Acupuncture 24 visits/benefit period
- Hearing Aids one hearing aid/ear every three years capped at $2,000 maximum/benefit period.
- Bariatric surgery
- Most coverage provided outside the United States. See www.bcbsglobalcore.com
- Chiropractic care 60 visits/benefit period
- Private-duty nursing

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.dmhc.ca.gov/, Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), 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 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 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

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.dmhc.ca.gov/

* For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/eocdps/ca/aso.
**Does this plan provide Minimum Essential Coverage?**  No
If you don’t have [Minimum Essential Coverage](https://eoc.anthem.com/eocdps/ca/aso) 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?**  No
If your plan doesn’t meet the [Minimum Value Standards](https://eoc.anthem.com/eocdps/ca/aso), you may be eligible for a [premium tax credit](https://eoc.anthem.com/eocdps/ca/aso) to help you pay for a plan through the [Marketplace](https://eoc.anthem.com/eocdps/ca/aso).

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 plan's overall deductible $0
- Specialist copayment $15
- Hospital (facility) copayment $250
- Other coinsurance 0%

This EXAMPLE event includes services like:
- Specialist office visits (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (ultrasounds and blood work)
- Specialist visit (anesthesia)

Total Example Cost $12,800

In this example, Peg would pay:
- Cost Sharing
  - Deductibles $0
  - Copayments $600
  - Coinsurance $0
  - What isn't covered Limits or exclusions $60
  - The total Peg would pay is $660

Managing Joe’s type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)
- The plan's overall deductible $0
- Specialist copayment $15
- Hospital (facility) copayment $250
- Other coinsurance 0%

This EXAMPLE event includes services like:
- Primary care physician office visits (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs
- Durable medical equipment (glucose meter)

Total Example Cost $7,400

In this example, Joe would pay:
- Cost Sharing
  - Deductibles $0
  - Copayments $1,000
  - Coinsurance $0
  - What isn't covered Limits or exclusions $60
  - The total Joe would pay is $1,060

Mia’s Simple Fracture
(in-network emergency room visit and follow up care)
- The plan's overall deductible $0
- Specialist copayment $15
- Hospital (facility) copayment $250
- Other coinsurance 0%

This EXAMPLE event includes services like:
- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

Total Example Cost $1,900

In this example, Mia would pay:
- Cost Sharing
  - Deductibles $0
  - Copayments $100
  - Coinsurance $0
  - What isn't covered Limits or exclusions $60
  - The total Mia would pay is $100

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, kenë të drejtë të merrni fa lash ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (833) 674-9256

**Amharic (አማርኛ):** ከአማርኛ ከእርዳታ ከእርዳታ ያለው ያስገነዝባል ከእርዳታ ከእርዳት ያለው ከእርዳታ ከእርዳት ያለው ያስገነዝባል ከእርዳታ ከእርዳት ያለው ከእርዳታ ከእርዳት ያለው ያስገነዝባል ከእርዳታ ከእርዳት ያለው ከእርዳታ ከእርዳት ያለው ያስገነዝባል ከእርዳታ ከእርዳታ ያለው ከእርዳታ ከእርዳታ ያለው ያስገነዝባል ከእርዳታ ከእርዳታ ያለው ከእርዳታ ከእርዳታ ያለው ከእርዳታ ከእርዳታ ያለው ከእርዳታ ከእርዳታ ያለው ያስገነዝባል ከእርዳታ ከእርዳታ ያለው ከእርዳታ ከእርዳታ ያለው ከእርዳታ ከእርዳታ ያለው ያስገነዝባል ከእርዳታ ከእርዳታ ያለው ከእርዳታ ከእርዳታ ያለው ያስገነzem (833) 674-9256

**Arabic** (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فحقق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (833) 674-9256.

**Armenian (հայերեն).** Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն լեզվով, որը զավակից է ձեր լեզվին: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (833) 674-9256:

**Bassa (Bàssò Wùfù):** M dyi diy-die-dè bë bëdë ba céè-dè nià ke dyì ni, c ì mò ni dyi-bèqèèm-dë bë m ke gbo-kpá-kpá ke bò kpò dë m bìqì-wùfùün bò pìdyì. Bë m ke wùfù-zìì-nìì yò dë bò wùfù ke fà, (833) 674-9256.

**Bengali (বাংলা):** যদি এই লিপিতের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষার বিলাসূল সাহায্য পাওয়ার ও ভাষা পাওয়ার অধিকার আপনার আছে। একজন দৌভাগ্যের সাথে কথা বলা জন্য (833) 674-9256 –তে কল করুন।

**Burmese (ကြားတော်):** သင်၏စာမျက်နှင့် ပတ်သက်သော သို့မဟုတ် စီးပွားရေး ပညာနှင့် လုပ်ငန်း၏ အခြေအနေများကို ကြေညာချက် ပြပေးခြင်း မရှိပေ။ သင်ကြောင်း အချက်အလက်များကို လေ့လာနိုင်ပါသည်။ (833) 674-9256

**Chinese (中文):** 如果您对本文件有任何疑问，您有权使用您的语言免费获得协助和资讯。如需与译员通电话，请致电(833) 674-9256。

**Dinka (Dinka):** Na nong thiee nê ke de yá thóoré, ke yin nong long bé yi kuony ku wer aku bé gëer yic yin ne thôn du ke cíin wëu tásu ke pyin. Te kor yin ba jäm wënê ran ye thok gyëic, ke yin col (833) 674-9256.

**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 (833) 674-9256.

**Farsi (فارسی):** در صورتی که سوالی پیرامون این صندوق دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینهایی به زبان مادریتان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره 7256 (833) 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 (833) 674-9256.

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 (833) 674-9256.

Greek (Ελληνικά): Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε τη δυνατότητα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (833) 674-9256.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ વગર આપની ભાષામાં મદદ અને માહહતી મેળવવાનો તમને અધિકાર છે. ફ્રેજરાયસા સાથે વાત કરવા માટે, કોલ કરો (833) 674-9256.

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 (833) 674-9256.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज के बारे में कोई प्रश्न हैं, तो आपको निष्पक्ष अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। 

Gujara ti se bhat karne ke ilay, kal karre (833) 674-9256.

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntisig 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 (833) 674-9256.

Igbo (Igbo): Ọ bụrụ na ọnwere ajuụ ọ bụla gbasara akwụkwọ a, ọnwere ikikẹ ịnweta enyemaka na ozi n'asụsụ ọ bụla na akwụgị ụgwọ ọ bụla. Ka ọ bụla n'okwu kwuo okwu, kpọọ (833) 674-9256.

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 (833) 674-9256.

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 (833) 674-9256.

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 (833) 674-9256

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ご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、(833) 674-9256 にお電話ください。
Language Access Services:

Khmer (ខ្មែរ): ពេញវិញការបង្កើតប្រព័ន្ធផ្សព្វផ្សាយវេបសាយ និងការប្រឈមប្រាក់ដូចជាការប្រឈមប្រាក់អំពីអាជីវករណ៍។ ដំបូងនេះអាចបានទទួលបានការជួយពីប្រព័ន្ធប្រឈមប្រាក់ដូចជា (833) 674-9256។

Kirundi (Kirundi): Uigure ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (833) 674-9256.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (833) 674-9256 로 문의하십시오.

Lao (ພາສາລາວ): ທ່ານ/ເន <<= ទາ/ អន✨ ໃຊ້ດ້ານບົດເດືອນຄວາມordanເອົາຂອງທ້ອງຖານ, ທ່ານ/ເນ >> ເຊັ່ນໜ້າຂຽວເຮັດວຽກຮັບໜ້າຊຸດຫຼື ລະດິດກ່າວຈະຍອມຈາກພະນະບາດຄວາມທາງທ່ານ/ເນ >>. ແຕ່ລ້າງທີ່ ເປັນໜ້າພະນະບາດຄວາມທາງທ່ານ/ເນ >> (833) 674-9256.

Navajo (Diné): Díi naaltsos bika’ígíí lahgo bina’idilkidgo ná bohónéedzá dóó bee ahóot’í’ t’áá ni nízaad k’éhí bee nił hodoonih t’áadoo bááh ilínágoó. Ata’ halne’ígíí la’ bíchí’ hadeesdzíh nínízíngó kojí’ hodilnih (833) 674-9256.

Nepali (नेपाली): यदि आपका मुद्दा तपाईंले क्यान्त उपायको रूपमा प्रस्तुत गर्नु भए, आपले भाषामा निजी: तक्तकाउन र तपाईको प्रास गर्न पाउने तपाईको प्रतिगमान छ। धीरामितिस्थि कुरा गर्नका तारीख, यहीरत गल्लोश (833) 674-9256.

Oromo (Oromifaa): Sanadi kanaa wajiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (833) 674-9256 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 (833) 674-9256.

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 (833) 674-9256.

Punjabi (ਪੰਜਾਬੀ): ਨੇ ਤੁਰਕੇ ਦੀ ਵਿਸ਼ਵਾਸੀ ਅਸਾਦੀ ਨੇ ਐਲ ਦਵਾਈ ਵਿਚ ਹੁਣ ਨਕਸ਼ਦ ਲੱਗਾ ਉਨ੍ਹਾਂ ਦੇਵ ਅਕਸ਼ ਲੀਡ ਹੁਣ ਨਕਸ਼ਦ ਲੱਗਾ ਨਹੀਂ ਨਾਕਾਸ਼ੀ ਭੂਪਤ ਵਰਤ ਦਾ ਪ੍ਰਾਚੀਨ ਹੁਣ। ਕਿਵੀ ਹੁੰਦਾ ਦੀਆਂ ਰੂਪ ਬਚਾਓ ਚਲਾਓ ਕਾਲੀ, (833) 674-9256 ਤੇ ਬਾਤ ਕਵਰ।
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.