

**Summary of Benefits and Coverage:** What this **Plan** Covers & What You Pay For Covered Services

**Coverage Period:** 01/01/2021– 12/31/2021

**Anthem Blue Cross Life and Health Insurance Company:**

**Coverage for:** Individual + Family | **Plan Type:** CDHP

**PRISM: County of Lake Custom HSA Bronze Plan - Anthem PPO HSA 2000/4000**


**30/50 - Hybrid Accumulation**



**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/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/](http://www.healthcare.gov/sbc-glossary/) or call (855) 826-0710 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	<b>\$2,000</b> /single or <b>\$6,000</b> /family for In- <u>Network Providers</u> . <b>\$4,000</b> /single or <b>\$12,000</b> /family for Non- <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 <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
<b>Are there services covered before you meet your deductible?</b>	Yes. <u>Preventive care</u> for In- <u>Network Providers</u> .	This <u>plan</u> 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 <u>plan</u> covers certain preventive services without <u>cost-sharing</u> and before you meet your <u>deductible</u> . 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> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	<b>\$6,450</b> /single or <b>\$12,900</b> /family for In- <u>Network Providers</u> . <b>\$12,700</b> /single or <b>\$38,100</b> /family for Non- <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 <u>plan</u> , 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 out-of-pocket limit?</b>	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> 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 network provider?</b>	Yes, Prudent Buyer PPO. See <a href="http://www.anthem.com/ca/prism">www.anthem.com/ca/prism</a> or call (855) 826-0710 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an out-of- <u>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 <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an out-of- <u>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 <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .
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 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 (You will pay the least)	Non-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	----- none-----
	<a href="#">Specialist</a> visit	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	----- none-----
	<a href="#">Preventive care</a> / <a href="#">screening</a> / <a href="#">immunization</a>	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	----- none-----
	Imaging (CT/PET scans, MRIs)	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	\$800 maximum/test for Non- <a href="#">Network Providers</a> .
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.anthem.com/ca/pharmacynformation/">http://www.anthem.com/ca/pharmacynformation/</a> National	Tier 1 - Typically Generic	30% <a href="#">coinsurance</a> (retail) and 30% <a href="#">coinsurance</a> (home delivery)	Not covered	Most home delivery is 90-day supply. *See <a href="#">Prescription Drug</a> section of the <a href="#">plan</a> or policy document (e.g. evidence of coverage or certificate).
	Tier 2 - Typically <a href="#">Preferred</a> / Brand	30% <a href="#">coinsurance</a> (retail) and 30% <a href="#">coinsurance</a> (home delivery)	Not covered	
	Tier 3 - Typically Non- <a href="#">Preferred</a> / <a href="#">Specialty Drugs</a>	30% <a href="#">coinsurance</a> (retail) and 30% <a href="#">coinsurance</a> (home delivery)	Not covered	
	Tier 4 - Typically <a href="#">Specialty</a> (brand and generic)	30% <a href="#">coinsurance</a> (retail) and 30% <a href="#">coinsurance</a> (home delivery)	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	\$350 maximum/day for Non- <a href="#">Network Providers</a> .
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	----- none-----
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	30% <a href="#">coinsurance</a>	Covered as In- <a href="#">Network</a>	30% <a href="#">coinsurance</a> for Emergency Room Physician Fee.
	<a href="#">Emergency medical transportation</a>	30% <a href="#">coinsurance</a>	Covered as In- <a href="#">Network</a>	----- none-----
	<a href="#">Urgent care</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	----- none-----

\* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/ca/aso>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	\$600 maximum/day for Non- <a href="#">Network Providers</a> .
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	----- none-----
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Office Visit 30% <a href="#">coinsurance</a> Other Outpatient 30% <a href="#">coinsurance</a>	Office Visit 50% <a href="#">coinsurance</a> Other Outpatient 50% <a href="#">coinsurance</a>	Office Visit Includes <a href="#">Durable Medical Equipment</a> Other Outpatient \$350 maximum/day for Non- <a href="#">Network Providers</a> . Includes <a href="#">Durable Medical Equipment</a>
	Inpatient services	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	\$600 maximum/day for Non- <a href="#">Network Providers</a> . 30% <a href="#">coinsurance</a> for Inpatient Physician Fee In- <a href="#">Network Providers</a> . 50% <a href="#">coinsurance</a> for Inpatient Physician Fee Non- <a href="#">Network Providers</a> .
<b>If you are pregnant</b>	Office visits	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	\$600 maximum/day for Non- <a href="#">Network Providers</a> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	100 visits/benefit period.
	<a href="#">Rehabilitation services</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	*See Therapy Services section
	<a href="#">Habilitation services</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	100 days limit/benefit period.
	<a href="#">Durable medical equipment</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	*See <a href="#">Durable medical equipment</a> section or Mental Health Substance Abuse section for those services.
<a href="#">Hospice services</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	----- none-----	
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	*See Vision Services section
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	*See Dental Services section

\* 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
- Eye exams for a child
- Infertility treatment
- Routine eye care (adult)
- Dental care (adult)
- Glasses for a child
- Long- term care
- Routine foot care unless you have been diagnosed with diabetes.
- Dental Check-up
- Hearing aids
- Private-duty nursing
- Weight loss programs

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

- Abortion
- Chiropractic care 30 visits/benefit period.
- Acupuncture 20 visits/benefit period.
- Most coverage provided outside the United States. See [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)
- Bariatric surgery

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

California Department of Insurance, Consumer Communications Bureau, 300 South Spring Street, South Tower, Los Angeles, CA 90013, 1-800-927-HELP (4357), 1-213-897-8921, 1-800-482-4TDD (4633), [www.insurance.ca.gov/](http://www.insurance.ca.gov/)

### Does this plan provide Minimum Essential Coverage? Yes/No

**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/No

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](#).

\* For more information about limitations and exceptions, see **plan** or policy document at <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)

n The <a href="#">plan's overall deductible</a>	<b>\$2,000</b>
n <a href="#">Specialist coinsurance</a>	<b>30%</b>
n <a href="#">Hospital (facility) coinsurance</a>	<b>30%</b>
n <a href="#">Other coinsurance</a>	<b>30%</b>

**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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$2,000
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$3,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$5,260</b>

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

n The <a href="#">plan's overall deductible</a>	<b>\$2,000</b>
n <a href="#">Specialist coinsurance</a>	<b>30%</b>
n <a href="#">Hospital (facility) coinsurance</a>	<b>30%</b>
n <a href="#">Other coinsurance</a>	<b>30%</b>

**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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$2,000
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$3,020</b>

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

n The <a href="#">plan's overall deductible</a>	<b>\$2,000</b>
n <a href="#">Specialist coinsurance</a>	<b>30%</b>
n <a href="#">Hospital (facility) coinsurance</a>	<b>30%</b>
n <a href="#">Other coinsurance</a>	<b>30%</b>

**This EXAMPLE event includes services like:**

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

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$2,000
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,200</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 (855) 826-0710

**Amharic (አማርኛ):-** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (855) 826-0710 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 (855) 826-0710.

**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) 826-0710:

**Bassa (Bàsɔ̀ Wùdù):** M̄ dyi dyi-diè-djè b̄ě b̄édjé b̄á céè-djè nià ke dyí ní, ɔ̀ m̀ò ni dyí-b̄èd̄jèin-djè b̄é m̄ ké gbo-kpá-kpá kè b̄ǎ kpǎ djé m̄ bídí-wùdùùn b̄ó pídyi. B̄é m̄ ké wuɖu-zìin-nyò d̄ò gbo wùdù ke, d̄á (855) 826-0710.

**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 (855) 826-0710 -তে কল করুন।

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (855) 826-0710 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 (855) 826-0710。

**Dinka (Dinka):** Na nɔŋ thiëc nē ke de yā thorē, ke yin nɔŋ loŋ bē yi kuony ku wēr alēu bē gēer yic yin ne thoŋ du ke cin wēu tāauē ke piny. Te kōr yin ba jam wēnē ran ye thok geryic, ke yin cəl (855) 826-0710.

**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 (855) 826-0710.

Farsi (فارسی): 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 (855) 826-0710 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) 826-0710.

## 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) 826-0710.

**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) 826-0710.

**Gujarat ગુજરાતી):** જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અર્હકોર છે. દલાભયા સાથ વાત કરવા માટ, કોલ કરો (855) 826-0710.

**Haitian Creole (Kreyòl Ayisyen):** Si ou gen nespòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (855) 826-0710.

**Hindi (हिंदी):** अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (855) 826-0710

**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 (855) 826-0710.

**Igbo (Igbo):** Ọ bụr ụ na ị nwere ajuju ọ bụla gbasara akwukwo a, ị nwere ikike ịnweta enyemaka na ozi n'asusu gi na akwughị ugwo ọ bụla. Ka gi na ọkọwa okwu kwuo okwu, kpoo (855) 826-0710.

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**Khmer (ខ្មែរ):** បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។  
ដើម្បីជ្រើសរើសភាសាអ្នកបកប្រែ សូមហៅ ។

**Lao (ພາສາລາວ):** ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.  
ເພື່ອໂອ້ນລັບກັບວ່າມແບພາສາ, ໃຫ້ໃບທາ

**Navajo (Diné):** Díí naaltsoos biká'ígíí lahgo bína'idíłkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo báąh ilínígóó.  
Ata' halne'ígíí la' bich'í' hadeesdzih nínízingo kojí' hodiílnih

**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

**Punjabi (ਪੰਜਾਬੀ):** ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ  
ਹੈ। ਇੱਕ ਦੁਬਾਰੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, ਤੇ ਕਾਲ ਕਰੋ।

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**Korean ( ): 가 가**  
(855) 826-0710

(855) 826-0710.

(855) 826-0710.

(855) 826-0710

**Oromo (Oromifa):** Sami kana wajin walqabaate gaffi kamiya yoo qabdu tanaan, Gargaarsa angachuu fi odeffanoo afaan ketim kaffatti alla argachuuf miqaa qabdaa. Tuqumaama dubaachuuf, (855) 826-0710 bilbilla.

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**Samoan (Samoa):** Afai e iai ni ou fesili e uiga i lenei tusi, e iai lou 'aia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se totoi. Ina ia talanoa i se tagata faaliliu, vili (855) 826-0710.

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## Language Access Services:

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