## Summary of Benefits and Coverage: What This Plan Covers & What You Pay for Covered Services

**Anthem® BlueCross**  
The Claremont Colleges, Inc: Custom Advantage HMO 15 or 25/300 admit

### Coverage Period:
01/01/2023 - 12/31/2023

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

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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/](https://eoc.anthem.com/eocdps/). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call (855) 333-5730 to request a copy.

### Important Questions

<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>$0</td>
<td>See the Common Medical Events chart below for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>No.</td>
<td>You will have to meet the deductible before the plan pays for any services.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</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>$1,500/single or $3,000/two-party or $4,500/family for Preferred Network Provider and In-Network Providers combined.</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>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, California Care HMO. See <a href="http://www.anthem.com/ca">www.anthem.com/ca</a> or call (855) 333-5730 for a list of network providers. Costs may vary by site of service and how the provider bills.</td>
<td>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 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>Yes.</td>
<td>This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.</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>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 provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$15/visit</td>
<td>$25/visit</td>
<td>Not covered</td>
<td>Virtual visits (Telehealth) benefits available.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$30/visit</td>
<td>$40/visit</td>
<td>Not covered</td>
<td>Virtual visits (Telehealth) benefits available.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>No charge</td>
<td>Not covered</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>No charge</td>
<td>No charge</td>
<td>Not covered</td>
<td>--------none--------</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No charge</td>
<td>No charge</td>
<td>Not covered</td>
<td>--------none--------</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1 - Typically Generic</td>
<td>$10/prescription (retail and home delivery)</td>
<td>$10/prescription (retail and home delivery)</td>
<td>50% coinsurance up to $250/prescription (retail) and Not covered (home delivery)</td>
<td>Most home delivery is 90-day supply. For more information, refer to “National Drug List” at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a>.</td>
</tr>
<tr>
<td></td>
<td>Tier 2 - Typically Preferred Brand &amp; Non-Preferred Generic Drugs</td>
<td>$30/prescription (retail) and $60/prescription (home delivery)</td>
<td>$30/prescription (retail) and $60/prescription (home delivery)</td>
<td>50% coinsurance up to $250/prescription (retail) and Not covered (home delivery)</td>
<td>*See Prescription Drug section of the plan or policy document (e.g. evidence of coverage or certificate).</td>
</tr>
<tr>
<td></td>
<td>Tier 3 - Typically Non-Preferred Brand and Generic drugs</td>
<td>$50/prescription (retail) and $100/prescription (home delivery)</td>
<td>$30/prescription (retail) and $60/prescription (home delivery)</td>
<td>50% coinsurance up to $250/prescription (retail) and Not covered (home delivery)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 4 - Typically Preferred Specialty (brand and generic)</td>
<td>30% coinsurance up to</td>
<td>30% coinsurance up to</td>
<td>50% coinsurance up to</td>
<td></td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see plan or policy document at [https://eoc.anthem.com/eocdps/](https://eoc.anthem.com/eocdps/).
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</tr>
</thead>
<tbody>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$100/visit</td>
<td>$100/visit</td>
<td>Not covered</td>
<td>-------none-------</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>No charge</td>
<td>Not covered</td>
<td>-------none-------</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td><strong>Emergency room care</strong></td>
<td>$150/visit</td>
<td>$150/visit</td>
<td>Covered as In-Network</td>
<td>Copay waived if admitted.</td>
</tr>
<tr>
<td></td>
<td><strong>Emergency medical transportation</strong></td>
<td>No charge</td>
<td>No charge</td>
<td>Covered as In-Network</td>
<td>-------none-------</td>
</tr>
<tr>
<td></td>
<td><strong>Urgent care</strong></td>
<td>$15/visit</td>
<td>$25/visit</td>
<td>Covered as In-Network</td>
<td>-------none-------</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>$300/admission</td>
<td>$300/admission</td>
<td>Not covered</td>
<td>-------none-------</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>No charge</td>
<td>Not covered</td>
<td>-------none-------</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>Office Visit $15/visit Other Outpatient No charge</td>
<td>Office Visit $25/visit Other Outpatient No charge</td>
<td>Office Visit Not covered Other Outpatient Not covered</td>
<td>Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient -------none-------</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>$300/admission</td>
<td>$300/admission</td>
<td>Not covered</td>
<td>-------none-------</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>$15/visit</td>
<td>$25/visit</td>
<td>Not covered</td>
<td>Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). *Coverage includes fertility preservation services, see Fertility Preservation section.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge</td>
<td>No charge</td>
<td>Not covered</td>
<td>-------none-------</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$300/admission</td>
<td>$300/admission</td>
<td>Not covered</td>
<td>-------none-------</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td><strong>Home health care</strong></td>
<td>$15/visit</td>
<td>$25/visit</td>
<td>Not covered</td>
<td>100 visits/benefit period for Preferred Network and In-Network Providers combined.</td>
</tr>
<tr>
<td></td>
<td><strong>Rehabilitation services</strong></td>
<td>$15/visit</td>
<td>$25/visit</td>
<td>Not covered</td>
<td>*See Therapy Services section.</td>
</tr>
<tr>
<td></td>
<td><strong>Habilitation services</strong></td>
<td>$15/visit</td>
<td>$25/visit</td>
<td>Not covered</td>
<td>-------none-------</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see [plan](https://eoc.anthem.com/eocdps/) or policy document at [https://eoc.anthem.com/eocdps/](https://eoc.anthem.com/eocdps/).
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</thead>
<tbody>
<tr>
<td>Skilled nursing care</td>
<td>No charge</td>
<td>No charge</td>
<td>Not covered</td>
<td>100 days/benefit period for skilled nursing services for Preferred Network and In-Network Providers combined.</td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>No charge</td>
<td>No charge</td>
<td>Not covered</td>
<td>*See Durable Medical Equipment Section</td>
<td></td>
</tr>
<tr>
<td>Hospice services</td>
<td>No charge</td>
<td>No charge</td>
<td>Not covered</td>
<td>---------none---------</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<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>Children's eye exam</td>
<td>No charge</td>
<td>No charge</td>
<td>Not covered</td>
<td>*See Vision Services section</td>
</tr>
<tr>
<td>Children's glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>---------none---------</td>
</tr>
<tr>
<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>

**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)
- Glasses for a child
- Long-term care
- Weight loss programs

- Dental care (Pediatric)
- Hearing aids
- Non-emergency care when traveling outside the U.S.

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

- Acupuncture
- Private-duty nursing in a Home Setting only

- Bariatric surgery
- Routine eye care (Adult) 1 exam/benefit period

- Chiropractic care 60 visits/benefit period combined with all other therapies

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/](https://www.dmhc.ca.gov/), Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](https://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](https://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 or policy document at [https://eoc.anthem.com/eocdps/](https://eoc.anthem.com/eocdps/).
documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

ATTN: Grievances and Appeals, P.O. Box 4310, Woodland Hills, CA 91365-4310

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

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/

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/

**Does this plan provide Minimum Essential Coverage?** Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet the Minimum Value Standards?** Yes
If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/eocdps/.
## 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: $30
- Hospital (facility) copayment: $300
- 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: $12,700

In this example, Peg would pay:

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

What isn’t covered:
- Limits or exclusions: $60

The total Peg would pay is $360

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### 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: $30
- Hospital (facility) copayment: $300
- 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: $5,600

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

What isn’t covered:
- Limits or exclusions: $20

The total Joe would pay is $1,220

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

- The plan's overall deductible: $0
- Specialist copayment: $30
- Hospital (facility) copayment: $300
- 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: $2,800

In this example, Mia would pay:

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

What isn’t covered:
- Limits or exclusions: $0

The total Mia would pay is $300

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The plan would be responsible for the other costs of these EXAMPLE covered services.
Language Access Services:

(TTY/TDD: 711)

Albanian (Shqip): Nëse kenë pyetje në lidhje me këtë dokument, kenë të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi 1-888-254-2721

Amharic (አማርኛ): ከአማርኛው የስለዚህ ሀሳብ ይገኛል ያቁር የተግል የስለዚሁ ያስከሚገር ከምር የተግል መልጣን ያስከሚገር፣ ከአማርኛው ከአማርኛ ያህ ይጠቅ ከአማርኛው ያስከሚገር፣ 1-888-254-2721 ይጨምር።

Arabic: إذا كان لديك أي استفسارات بشأن هذا المستند، فتحصل له الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على 1-888-254-2721.

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկություն։ Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ 1-888-254-2721:


Bengali (বাংলা): যদি এই লিপিতে বিষয়ে আগন্তুকের কোনো প্রশ্ন থাকে, তাহলে আগন্তুকের ভাষায় নিয়মিত সহায়তা পাওয়ার ও তথ্য পাওয়ার অধিকার আগন্তুকের আছে। একজন দোভাষীর সাথে কথা কথার জন্য 1-888-254-2721 -তে কল করুন।

Language Access Services:

French (Français): Si vous avez des questions sur ce document, vous avez la possibilité d’accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le 1-888-254-2721.

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie 1-888-254-2721.

Greek (Ελληνικά): Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο 1-888-254-2721.

Gujarati (ગુજરાતી): જો આ દર્શાવેલું અંગે આપને કોઈપણ પ્રશ્ન પડો હોય તો, કોઈપણ અભિગમન વગર આપની ભાષી માદ્ય અને માદિતી મેન્યુમા તમામ અવિકાર છે. દુભાષિય સાથે વાત કરવા માટે, ડિલ્ટ્રો કરો 1-888-254-2721.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele 1-888-254-2721.

Hindi (हिंदी): अगर आपके पास इस दर्शावेज के बारे में कोई प्रश्न हैं, तो आपको नि:शुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिय बात करने के लिए, कॉल करो 1-888-254-2721.


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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 1-888-254-2721.

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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 1-888-254-2721.

Japanese (日本語): この文書についてなにか不明な点があれば、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 1-888-254-2721 にお電話ください。
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Khmer (អាលាម): ប្រឈប់ការបញ្ជាក់អំពីសេវាដែលនេះទេ?: អាលាមជឿប្រភេទនេះសំដៅនឹងសមាជិកសេវាកម្មជាច្រើនដែលមានការអំពីសេវាកម្មជាច្រើនអំពីមុខងារក្នុងក្រុមហ៊ុនថ្មី។ តាមរយៈលេខ 1-888-254-2721

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura 1-888-254-2721.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 1-888-254-2721 로 문의하십시오.

Lao (ພາສາລາວ): ເຖິງກ່ຽວກັບຕໍ່ການບងlongleftrightarrow, ທ່ານມີການຊ່ວຍເຫຼືອດ້ວຍຊ່ວຍເຫຼືອໜ້າທີ່ສະມາຊິກ ແລະ ສ່ວຍຂ່າວການຊ່ວຍເຫຼືອຂອງທ້ອງຖິ່ນຂອງທ້ອງຖິ່ນ. ດ້ວຍທີ່ດັ່ງກ່າວ, ຋ັນທີ່ 1-888-254-2721.

Navajo (Diné): Díí naaltsoos biká'íi guhó bina'ídíkídgo ná bohónéédzá dóó bee ahóó'tíi t'àá ni nízaad k’ehjí bee nił hodoonih t’aadoo báá báñil ilíñígóó. At’a halne’íí ju la’í bi’hi’ hadeesdzíh níñiñíno koju hodiilnih 1-888-254-2721.

Nepali (नेपाली): यदि यो कार्यालयोंको तपाईं रेखां महत्त्वपूर्ण छूँक भने, आफ्नो भाषामा निश्चित सहयोग र तपाईंको जानकारी प्राप्त गर्न पाउने लागू तपाईं रेखां महत्त्वपूर्ण छ। तीन विषयमा कुरा गर्नुका लागि, यहाँ कल गर्नुहोस् 1-888-254-2721.

Oromo (Oromifaa): Sanadi kanaa wajiin walaqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuuf fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, 1-888-254-2721 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 totogi. Ina ia talanoa i se tagata faaliliu, vili 1-888-254-2721.


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Thai (ไทย): หากท่านมีค าถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร 1-888-254-2721 เพื่อพูดคุยกับกล่าว

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Yiddish (אידיש): acknowledgement. For more information, please call 1-888-254-2721.

Yoruba (Yorùbá): Tí o bá ní èyíkèyì íbèrè nipa àkọsile yí, o ní èyò látì gba ìrànwò àti ìwí́n ní èdè rẹ̀ lọ́fẹ. Bá wá ógbúró kán só, pé 1-888-254-2721.
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