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

**Coverage Period:** 07/01/2022 - 06/30/2023

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

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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/aso](https://eoc.anthem.com/eocdps/aso). For general definitions of common terms, such as *allowed amount*, *balance billing*, *coinsurance*, *copayment*, *deductible*, *provider*, or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](https://www.healthcare.gov/sbc-glossary/) or call (855) 634-3383 to request a copy.

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### 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>$500/person or $1,000/family for In-Network Providers, $500/person or $1,000/family for Non-Network Providers.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this <strong>plan</strong> begins to pay. If you have other family members on the <strong>plan</strong>, 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>
</tbody>
</table>

| **Are there services covered before you meet your deductible?** | **Yes. Preventive Care** 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/](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?** | $3,000/person or $6,000/family for In-Network Providers, $3,000/person or $6,000/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?** | Services deemed not medically necessary by Medical Management and/or Anthem, 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 provider?** | **Not Applicable.** | This **plan** does not use a provider network. You can receive covered services from any provider. |

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KY/LG/University of Kentucky: UK-IND Plan/QAZ2/07-22
## Do you need a referral to see a specialist?

No. You can see the specialist you choose without a referral.

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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>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>20% coinsurance</td>
<td>20% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/Immunization</td>
<td>No charge</td>
<td>No charge</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>20% coinsurance</td>
<td>20% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>none</td>
</tr>
</tbody>
</table>
| If you need drugs to treat your illness or condition | Tier 1 - Generic                                 | 20% coinsurance (30-day Rx)                | Not covered                                 | $8 minimum/$50 maximum (30-day Rx, any pharmacy)  
$24 minimum/$100 maximum (90-day UK Phcy/Mail Order) |
|                      | Tier 2 - Preferred Brand                          | 40% coinsurance (30-day Rx)                | Not covered                                 | $20 minimum/$60 maximum (30-day Rx any pharmacy)  
$60 minimum/$120 maximum (90-day UK Phcy/Mail Order) |
|                      | Tier 3 - Non-Preferred Brand                      | 50% coinsurance (30-day Rx)                | Not covered                                 | $60 minimum (30-day Rx any pharmacy)  
$120 minimum (90-day Rx UK Phcy/Mail Order) |
|                      | Specialty Generic                                 | 20% coinsurance                            | Not covered                                 | $8 minimum/$50 maximum (per 30-day Rx)               |
|                      | Specialty Brand                                  | $200 per 30 day Rx                        | Not covered                                 | none                                                  |

Separate pharmacy out-of-pocket limits apply. Single-$4,900 Family-$9,800

* For more information about limitations and exceptions, see plan or policy document at 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>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$100/visit then 20% coinsurance deductible does not apply</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office Visit 20% coinsurance</td>
<td>Office Visit 20% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other Outpatient 20% coinsurance</td>
<td>Other Outpatient 20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/eocdps/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.)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered).
- Dental care (Pediatric)
- Routine eye care (Adult)
- Tier 2 - Typically Preferred / Brand Specialty Brand
- Cosmetic surgery
- Dental Check-up
- Long-term care
- Routine foot care unless you have been diagnosed with diabetes.
- Tier 3 - Typically Non-Preferred / Specialty Drugs
- Weight loss programs
- Dental care (Adult)
- Glasses for a child
- Private-duty nursing
- Tier 1 - Typically Generic
- Specialty Generic

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

- Acupuncture 45 visits/benefit period for physical therapy, occupational therapy, speech therapy, Cardiac therapy, and manipulative treatment.
- Most coverage provided outside the United States. See www.bcbsglobalcore.com
- Bariatric surgery
- Spinal Manipulation 45 visits/benefit period for physical therapy, occupational therapy, speech therapy, Cardiac therapy, and Acupuncture.
- Hearing aids one/ear every 36 months under age 18.

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 Insurance, 215 West Main Street, Frankfort, Kentucky 40601, (502) 564-3630, (800) 595-6053, TTY: (800) 648-6056, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.cciio.cms.gov, 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 105568, Atlanta GA 30348-5568


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

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)</th>
<th>Managing Joe’s Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia’s Simple Fracture (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td>■ The plan's overall deductible</td>
<td>■ The plan's overall deductible</td>
<td>■ The plan's overall deductible</td>
</tr>
<tr>
<td>$500</td>
<td>$500</td>
<td>$500</td>
</tr>
<tr>
<td>■ Specialist coinsurance</td>
<td>■ Specialist coinsurance</td>
<td>■ Specialist coinsurance</td>
</tr>
<tr>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>■ Hospital (facility) coinsurance</td>
<td>■ Hospital (facility) coinsurance</td>
<td>■ Hospital (facility) coinsurance</td>
</tr>
<tr>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>■ Other coinsurance</td>
<td>■ Other coinsurance</td>
<td>■ Other coinsurance</td>
</tr>
<tr>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
</tbody>
</table>

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)*

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)*

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

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$12,700</th>
<th>$5,600</th>
<th>$2,800</th>
</tr>
</thead>
</table>

In this example, Peg would pay:
- **Cost Sharing**
  - Deductibles: $500
  - Copayments: $0
  - Coinsurance: $2,400

What isn’t covered:
- Limits or exclusions: $60
- **The total Peg would pay is**: $2,960

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$5,600</th>
</tr>
</thead>
</table>

In this example, Joe would pay:
- **Cost Sharing**
  - Deductibles: $500
  - Copayments: $0
  - Coinsurance: $1,700

What isn’t covered:
- Limits or exclusions: $20
- **The total Joe would pay is**: $2,220

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$2,800</th>
</tr>
</thead>
</table>

In this example, Mia would pay:
- **Cost Sharing**
  - Deductibles: $500
  - Copayments: $100
  - Coinsurance: $400

What isn’t covered:
- Limits or exclusions: $0
- **The total Mia would pay is**: $1,000

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 gjyshën tuaj. Për të kontaktuar me një përkthyes, telefononi (855) 634-3383

Amharic (አማርኛ): ለፋለቹ ኪትርጌ ከሚት ያለት ያለት ያለት ከሚት ያለት ለፋለቹ ከሚት ያለት ከሚት ያለት ከሚት ከሚት ከሚONSE (855) 634-3383 të ከሚት ከሚት .

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فإنك تحق لك الحصول على المساعدة والمعلومات بلغتك بدون مقابل. للتحدث إلى مترجم، اتصل على (855) 634-3383.

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն։ Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (855) 634-3383:

Bassa (Bàssà Wùqù): M dyi dyi-dié-që bë béché bá céé-dë nià ke dyi ní, c mò ni dyi-dëqën-dë bë m ke gbo-kpá-kpá kë bò kpó dë m bëči-wùqùün bë pìdy. Bë m ke wùqù-zìnn-nyò dë bë wùqù ke, dà (855) 634-3383.

Bengali (বাংলা): যদি এই লিখিতের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষার বিলাসূত্ত্ব সাহায্য পাওয়া ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোষারীর সাথে কথা বলা জন্য (855) 634-3383.

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信息。如需与翻译通话，请致电(855) 634-3383。

Dinka (Dinka): Na nac thëcc nè ke de ya thore, ke yin nac log bé yi kuony ku wer ale bë geér yic yin ne thon du ke ciin wëu tääué ke piny. Te kër yin ba jam wënc ran ye thok geryic, ke yin col (855) 634-3383.

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) 634-3383.
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 (855) 634-3383.

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) 634-3383.

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 διευθυντή, τηλεφωνήστε στο (855) 634-3383.

Gujarati (ગુજરાતી): જો આ દસ્તાબ્દી અંગે આપને કોઈપણ પ્રશ્ન આવી તો, કોઈપણ વગર આપની ભાષામાં મધ્ય અને માહિતી મેળવવાનો તમને અધિકાર છે. ફ્રેંચ સાથે વાત કરવા માટે, કોલ કરો (855) 634-3383.

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) 634-3383.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज 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) 634-3383.

Hmong (White Hmong): Yog tias kjo muaj lus nug dab tsi ntsig txog daim ntawv no, kjo muaj cai tau txais kev pab thib lus qhia hais ua kjo hom lus yam tsim xam tus ni. Txawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (855) 634-3383.

Igbo (Igbo): Ọ bụrụ na ị nwere ajụju ọ bula gbasara akwụkwọ a, ị nwere ịkike ịnweta enyemaka na ozi n’asụsụ gị na awụghị ụgwọ ọ bula. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (855) 634-3383.

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 (855) 634-3383.

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) 634-3383.

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) 634-3383.

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 (855) 634-3383 にお電話ください。
Language Access Services:

Khmer (ខ្មែរ): ប្រើប្រាស់ប្រយោគជាមួយនឹងការបញ្ជាក់សម្រាប់: អ្នកប្រើប្រាស់មានសុំបញ្ចូលការបង្កើតប្រយោគសារព័ត៌មានអំពីឈ្មោះនេះ។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umumwizi, akura (855) 634-3383.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(855) 634-3383 로 문의하십시오.

Lao (ພາສາລາວ): คำแยงก์มีคำหรือบางประโยคที่ไม่เข้าใจ, สามารถติดต่อเพื่อขอความช่วยเหลือได้. ติดต่อ (855) 634-3383.

Navajo (Diné): Díí náaltsos kimíí biyó bina’idilkidgo ná bohónédzą dóó bée ahóót’í’ t’áá ni nízaad k’éhí bée nił hodoońih t’aiadóó báách ilínigóó. Ata’ halné’íí bi’ bích’í’ hadeesdzhī nimííngo kojj’ hodúlnih (855) 634-3383.

Nepali (नेपाली): यदि आप कानाजातारे तपाईंलाई केही प्रश्न छनै भए, आफ्नो भाषामा निश्चित सहयोग तथा जानकारी प्राप्त गर्न पाउने तपाईंलाई केही प्रश्न छाए। आफ्नो प्रश्नको बारे मतेको लाग्ने, यहाँ कल गर्नुहोस् (855) 634-3383.

Oromo (Oromifaa): Sanadi kanaa wajiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (855) 634-3383 bilbilla.


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Punjabi (ਪੰਜਾਬੀ): ਸੁਰਖਤ ਦੇਸਤਾਂ ਦੀ ਪ੍ਰਾਣੀ ਵੇਗ ਵੇਗ ਵੇਗ ਦੇ ਹੁੰਦੇ ਹੋਏ, ਅਤੇ ਹੈ ਕਿ ਤੁਹਾਡੀ ਦੱਸੋ ਖੁਦ ਵੇਸ਼ ਪ੍ਰਫੈਕਟ ਜਾਂ ਪ੍ਰਫੈਕਟ ਹੇਠ ਵੇਗ ਵੇਗ ਵੇਗ। ਹੋਰ ਵਾਲੀ ਦਰਜਾਤ ਵਾਲੀ (855) 634-3383 ਦੇ ਵਾਲੀ ਹੋਏ।
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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 (855) 634-3383.

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Thai (ไทย): หากท่านมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร (855) 634-3383 เพื่อพูดคุยกับล่าม

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Yoruba (Yorùbá): Òdò ò lèhí ókùrẹ̀ ìdèrè nipa àkòsìlẹ̀ yìí, ó ní ètò láti gba irtówò àti ìwùíàn ní èdè rẹ̀ ìlọ̀wọ̀. Bá wa ogbùrù kẹ́n sọ́rọ̀, pé (855) 634-3383.
Language Access Services:
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