### Important Questions

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>For in-network providers $2,200 individual / $4,400 family For out-of-network providers $4,400 individual / $8,800 family Does not apply to in-network preventive care.</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>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive care for In-Network and Out-of-Network providers.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</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>For in-network providers $3,700 individual / $7,400 family For out-of-network providers $7,400 individual / $14,800 family</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</td>
<td>Yes, Blue Open Access POS. See</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s</td>
</tr>
</tbody>
</table>

Questions: Call 1-800-424-8950 or visit us at www.anthem.com/usg
you use a network provider?  
www.anthem.com/usg or call (800) 424-8950 for a list of network providers.

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

Do you need a referral to see a specialist?  
No.  
You can see the specialist you choose without a referral.

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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>What You Will Pay</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%</td>
<td>---------------none-------------</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>20%</td>
<td>---------------none-------------</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/imunization</td>
<td>No charge</td>
<td>40% coinsurance does not apply</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20%</td>
<td>---------------none-------------</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1 - Typically Generic</td>
<td>20% coinsurance after deductible</td>
<td>40% coinsurance; balance billing applies</td>
</tr>
<tr>
<td>More information about prescription drug coverage is available by contacting your pharmacy vendor, CVS Caremark at 877-362-3922</td>
<td>Tier 2 - Typically Preferred / Brand</td>
<td>20% coinsurance after deductible</td>
<td>40% coinsurance; balance billing applies</td>
</tr>
<tr>
<td></td>
<td>Tier 3 - Typically Non-Preferred / Specialty Drugs</td>
<td>20% coinsurance after deductible</td>
<td>40% coinsurance; balance billing applies</td>
</tr>
<tr>
<td></td>
<td>Tier 4 - Typically Specialty (brand and generic)</td>
<td>20% coinsurance after deductible</td>
<td>40% coinsurance; balance billing applies</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td>Emergency room care</td>
<td>20%</td>
<td>40%</td>
</tr>
</tbody>
</table>

More information about prescription drug coverage is available by contacting your pharmacy vendor, CVS Caremark at 877-362-3922.

Limit to a 30 day supply (90-day supply limit for maintenance drugs). Some medications may require pre-authorization or step-therapy.

Mail order coverage is available.

Failure to obtain preauthorization may result in non-coverage or reduced coverage.

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* For more information about limitations and exceptions, see plan or policy document at www.anthem.com/usg.
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</table>
| If you need immediate medical attention                  | Emergency medical transportation            | 20%  
Out-of-Network Provider (You will pay the most)        | Failure to obtain preauthorization may result in non-coverage or reduced coverage. |
|                                                          | Urgent care                                 | 20%  
Out-of-Network Provider (You will pay the most)        | ---none---                                              |
| If you have a hospital stay                              | Facility fee (e.g., hospital room)          | 20%  
Out-of-Network Provider (You will pay the most)        | Failure to obtain preauthorization may result in non-coverage or reduced coverage. |
|                                                          | Physician/surgeon fees                      | 20%  
Out-of-Network Provider (You will pay the most)        | ---none---                                              |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                          | 20%  
Out-of-Network Provider (You will pay the most)        | Office Visit:  
---none---  
Other Outpatient:  
---none--- |
|                                                          | Inpatient services                          | 20%  
Out-of-Network Provider (You will pay the most)        | Failure to obtain preauthorization may result in non-coverage or reduced coverage. |
| If you are pregnant                                      | Office visits                               | 20%  
Out-of-Network Provider (You will pay the most)        | ---none---                                              |
|                                                          | Childbirth/delivery professional services  | 20%  
Out-of-Network Provider (You will pay the most)        | ---none---                                              |
|                                                          | Childbirth/delivery facility services      | 20%  
Out-of-Network Provider (You will pay the most)        | ---none---                                              |
| If you need help recovering or have other special health needs | Home health care                            | 20%  
Out-of-Network Provider (You will pay the most)        | ---none---                                              |
|                                                          | Rehabilitation services                     | 20%  
Out-of-Network Provider (You will pay the most)        | Physical, Occupational, Athletic Trainers, and Chiropractic care services are limited to 20 visits/calendar year combined, in- and out-of-network combined.  
Speech therapy limited to 20 visits/calendar year, in- and out-of-network combined.  
Respiratory therapy limited to 30 visits/calendar year, in- and out-of-network combined.  
Limited to 30 days/calendar year, combined in- and out-of-network. |
|                                                          | Habilitation services                       | 20%  
Out-of-Network Provider (You will pay the most)        | ---none---                                              |
|                                                          | Skilled nursing care                        | 20%  
Out-of-Network Provider (You will pay the most)        | ---none---                                              |
|                                                          | Durable medical equipment                   | 20%  
Out-of-Network Provider (You will pay the most)        | ---none---                                              |
|                                                          | Hospice services                            | 0% coinsurance  
Out-of-Network Provider (You will pay the most)        | ---none---                                              |

* For more information about limitations and exceptions, see plan or policy document at www.anthem.com/usg.
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<tbody>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>No Charge</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>N/A</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see plan or policy document at www.anthem.com/usg.
Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acupuncture</td>
</tr>
<tr>
<td>• Dental care (adult)</td>
</tr>
<tr>
<td>• Long-term care</td>
</tr>
<tr>
<td>• Routine foot care unless you have been diagnosed with diabetes.</td>
</tr>
</tbody>
</table>

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

| • Chiropractic care 20 visits/benefit period. | • Most coverage provided outside the United States. See www.bcbsglobalcore.com | • Routine eye care (adult) |

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Georgia Office of Insurance and Safety Fire Commissioner, Consumer Services Division 2, Martin Luther King, Jr. Drive, WestTower, Suite 716, Atlanta, Georgia 30334, (800) 656-2298, www.oci.ga.gov/ConsumerService/Home.aspx. Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), 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 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 105449, Atlanta, GA 30548-5449
Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform
Georgia Office of Insurance and Safety Fire Commissioner, Consumer Services Division 2, Martin Luther King, Jr. Drive, WestTower, Suite 716, Atlanta, Georgia 30334, (800) 656-2298, www.oci.ga.gov/ConsumerService/Home.aspx

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

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

* For more information about limitations and exceptions, see plan or policy document at www.anthem.com/usg.
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) | Managing Joe's type 2 Diabetes  
(a year of routine in-network care of a well-controlled condition) | Mia’s Simple Fracture  
(in-network emergency room visit and follow up care) |
|---|---|---|
| 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) |
| Total Example Cost | $12,840 | $7,460 | $2,010 |
| In this example, Peg would pay:  
**Cost Sharing**  
Deductibles | $2,200 | $2,200 | $2,200 |
| Copayments | $0 | $0 | $0 |
| Coinsurance | $1,500 | $959 | $0 |
| **What isn't covered**  
Limits or exclusions | $96 | $220 | $0 |
| The total Peg would pay is | $3,796 | $1,179 | $1,540 |

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 përkkthyes, telefononi (855) 397-9267

Amharic (አማርኛ): የግለ ልምነት ከስለምንት ከምና ከምክ, የጠንቀቀስ ከሚያስፈጻሚ ከማስፈርነትና ከስለምንትነት ለማለት ይቀላ.CreateInstance: የተቀለጡትን ከስለምንት ከጠበቀ ከሚለጤ ከስለምንትነት ለተለጠ (855) 397-9267:

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) 397-9267:

Chinese (中): 如果您对本文件有任何问题，您有权免费获取所需信息和翻译服务。如果您需要与翻译通话，请拨打 (855) 397-9267。

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) 397-9267.

Farsi (فارسی): در صورتی که سوالی پیرامون این سند داردید، این حق را دارید که اطلاعات و کمک را بدون هیچ نیاز به جزایی به شما بدهیم. برای گفتگو با یک مترجم شفاهی، با شماره 7296-397-9267 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) 397-9267.
Language Access Services:

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Ansprüche auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, rufen Sie (855) 397-9267.

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 έναν διερμηνέα, τηλεφωνήστε στο (855) 397-9267.

Gujarati (ગુજરાતી): જે આ દસ્તાવેજ અને આ પ્રશંસા કોઈપણ કોઈપણ વર્ગે અથવા ભાષાના મુખ્ય મેધાવી મેળવવા તમામ અધિકાર છે. દૃશ્યાંત્રિક સાથે બાંધકામ કરવા માટે, કોલ કરો (855) 397-9267.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn ed ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (855) 397-9267.

Hindi (हिंदी): आप भाषा प्राप्ति प्रमाण पाता है, जो आपको शुल्क अथवा भाषा में मदद के लिए अधिकार कार्य करने का अधिकार है।

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) 397-9267.

Igbo (Igbo): Ọ bụrụ na i nwere ajụjụ, ọ bụla gbasara akwụkwọ a, i nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ugwo ọ bụla. Ọ ga gị na ọkọwa okwu kwuo okwu, kpọọ (855) 397-9267.

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 maya nga tagipatarus, awagan ti (855) 397-9267.

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) 397-9267.

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) 397-9267.

Japanese (日本語): この文書についてならびにお不明な点があれば、あなたにはあなたのお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) 397-9267 にお電話ください。
Language Access Services:

**Khmer** (ខ្មែរ): ប្រសិនបើការប្រការពីអំណាងនេះមិនសំខាន់៖ អ្នកអាចទទួលបានសេវាកម្មប្រការជាមួយនឹងការប្រការបន្ទះនេះ។ ទូរស័ព្ទ (855) 397-9267។

**Kirundi** (Kirundi): Ukige ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (855) 397-9267.

**Korean** (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (855) 397-9267 로 문의하십시오.

**Lao** (ລາວ): ບໍລິການມືກັບການຈັດປະຈຸບັນແບບອັງຄິດ, ທ່ານມີສາຂາໂດຍສະນຸດາມັດຊະນະທີ່ດັດເດດທຽມມາແນວໜ້າແຕ່ນ້ອຍທີ່ຕ້ັງ. ເທີ່ດະນານີ້ແດ່ງປະຕິດສະຫວາຍ, ໂດຍທ່ານ (855) 397-9267.

**Navajo** (Diné): Dii naaltsoos biká’íí giilé áh díí bina’idilkidgo ná bohóíedzá dóó bée ahóó’i’ t’áá ni nízaad k’ehjí bée níl hodoodih t’áadóó bááh ilinígóó. Ata’ halné’ig’é lá’ bích’í’ hateedszhí níminíngó kojí’hodiilnih (855) 397-9267.

**Nepali** (नेपाली): यदि आपको इस आदेश के संबंध में दोषी प्रश्न है, आपके भाषामा निष्केषण सहयोग तथा जानकारी प्राप्त बनाने हेतु तपाईको चर्चा छ। दोमामेसेन्स तुरा गर्नुका लागि, यहाँ कल गर्नुहोस् (855) 397-9267.

**Oromo** (Oormifaa): Sanadi kanaa wajiin walqaabate gaffi kamiyu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (855) 397-9267 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 (855) 397-9267.

**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 (855) 397-9267.

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