

Your summary of benefits



Anthem® Blue Cross

Your 2023 Contract Code: 8NAJ

Your Plan: Anthem Gold Priority Select HMO 35/1250/20% RxD

Your Network: Priority Select HMO

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. Unless stated otherwise, services received in an office, Ambulatory Surgical Center, or outpatient facility are combined across all outpatient settings. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

Anthem Blue Cross HMO benefits are covered only when services are provided or coordinated by the primary care physician and authorized by the participating medical group or independent practice association (IPA); except OB/GYN services received within the member's medical group/IPA, and services for mental and nervous disorders and substance abuse. Benefits are subject to all terms, conditions, limitations, and exclusions of the EOC.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible <i>Your plan applies a separate Pharmacy Deductible to prescription drugs obtained at a pharmacy. See the Covered Prescription Drug Benefits section.</i>	\$1,250 person / \$2,500 family	Not covered
Overall Out-of-Pocket Limit <i>When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period.</i>	\$8,600 person / \$17,200 family	Not covered
<p><i>The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per member deductible and per member out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per member deductible or per member out-of-pocket limit.</i></p> <p><i>Your copays, coinsurance and deductible count toward your out-of-pocket limit. However, member cost sharing for adult vision services do not apply toward the out-of-pocket limit.</i></p>		
<p>Doctor Visits (virtual and office) <i>Your plan requires the selection of a Primary Care Physician (PCP). A referral from your Primary Care Physician (PCP) is required for Specialist care and most other providers for select covered services.</i></p>		
<p>Virtual Visits from online provider LiveHealth Online <i>for urgent/ acute medical and mental health and substance use disorder care via www.livehealthonline.com are covered at No charge.</i></p>		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Primary Care (PCP) and Mental Health and Substance Use Disorder Care <i>virtual and office</i>	\$35 copay per visit deductible does not apply	Not covered
Specialist Care <i>virtual and office</i>	\$60 copay per visit deductible does not apply	Not covered
Other Practitioner Visits Routine Maternity Care Prenatal Postnatal Retail Health Clinic Visit Chiropractic/Manipulation Therapy <i>Coverage is limited to 30 visits per year.</i> Acupuncture	No charge \$35 copay per visit deductible does not apply \$35 copay per visit deductible does not apply \$15 copay per visit deductible does not apply \$35 copay per visit deductible does not apply	Not covered Not covered Not covered Not covered Not covered
Other Services in an Office Allergy Testing Prescription Drugs - Dispensed in the office <i>For the drugs itself dispensed in the office through infusion/injection.</i> Surgery	\$35 copay per visit deductible does not apply 20% coinsurance deductible does not apply \$60 copay per surgery deductible does not apply	Not covered Not covered Not covered
Preventive care/screenings/immunizations <i>In-network preventive care is not subject to deductible, if your plan has a deductible.</i>	No charge	Not covered
Preventive care for Chronic Conditions <i>per IRS guidelines</i>	No charge	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><u>Diagnostic Services</u></p> <p>Lab</p> <p>Office <i>Office Cost Share applies only when Freestanding/Reference Labs are not used.</i></p> <p>Freestanding Lab/Reference Lab</p> <p>Outpatient Hospital</p>	<p>\$15 copay per visit deductible does not apply</p> <p>No charge</p> <p>20% coinsurance after deductible is met</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p>X-Ray</p> <p>Office</p> <p>Freestanding Radiology Center</p> <p>Outpatient Hospital</p>	<p>\$15 copay per visit deductible does not apply</p> <p>\$15 copay per visit deductible does not apply</p> <p>20% coinsurance after deductible is met</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p>Advanced Diagnostic Imaging - for example: MRI, PET and CAT scans</p> <p>Office</p> <p>Freestanding Radiology Center</p> <p>Outpatient Hospital</p>	<p>\$200 copay per visit deductible does not apply</p> <p>\$200 copay per visit deductible does not apply</p> <p>\$350 copay per visit after deductible is met</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><u>Emergency and Urgent Care</u></p> <p>Urgent Care (Office Setting)</p> <p>Emergency Room Facility Services <i>Emergency Room copay is waived if directly admitted to the hospital.</i></p> <p>Emergency Room Doctor and Other Services</p> <p>Ambulance Transportation <i>Authorized non-emergency, out of network ambulance services are limited to Anthem maximum payment of \$50,000 per occurrence.</i></p>	<p>\$35 copay per visit deductible does not apply</p> <p>\$300 copay per visit and 20% coinsurance after deductible is met</p> <p>No charge</p> <p>20% coinsurance after deductible is met</p>	<p>Not covered</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p><u>Outpatient Mental Health and Substance Use Disorder Care at a Facility</u></p> <p>Facility Fees</p> <p>Doctor Services</p>	<p>No charge</p> <p>No charge</p>	<p>Not covered</p> <p>Not covered</p>
<p><u>Outpatient Surgery</u></p> <p>Facility Fees</p> <p>Hospital</p> <p>Ambulatory Surgical Center</p> <p>Doctor and Other Services</p> <p>Hospital</p> <p>Ambulatory Surgical Center</p>	<p>20% coinsurance after deductible is met</p> <p>\$500 copay per visit after deductible is met</p> <p>No charge</p> <p>No charge</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p> <p>Not covered</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><u>Hospital Stay (all Inpatient stays including Maternity, Mental Health and Substance Use Disorder)</u></p> <p>Facility fees (for example, room & board)</p> <p>Physician and other services including surgeon fees</p>	<p>20% coinsurance after deductible is met</p> <p>No charge</p>	<p>Not covered</p> <p>Not covered</p>
<p>Home Health Care <i>Coverage is limited to 100 visits per year. Limits are combined for home health care and private duty nursing. Benefit limit and cost share applies to physical, occupational, speech, respiratory, cardiac and pulmonary therapy when performed as part of Home Health.</i></p>	<p>\$60 copay per visit deductible does not apply</p>	<p>Not covered</p>
<p>Rehabilitation services (for example, physical/speech/occupational therapy)</p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$35 copay per visit deductible does not apply</p> <p>20% coinsurance after deductible is met</p>	<p>Not covered</p> <p>Not covered</p>
<p>Habilitation services (for example, physical/speech/occupational therapy)</p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$35 copay per visit deductible does not apply</p> <p>20% coinsurance after deductible is met</p>	<p>Not covered</p> <p>Not covered</p>
<p>Pulmonary rehabilitation</p> <p>Office</p>	<p>\$35 copay per visit deductible does not apply</p>	<p>Not covered</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	20% coinsurance after deductible is met	Not covered
Cardiac rehabilitation		
Office	\$35 copay per visit deductible does not apply	Not covered
Outpatient Hospital	20% coinsurance after deductible is met	Not covered
Dialysis/Hemodialysis		
Office	20% coinsurance deductible does not apply	Not covered
Outpatient Hospital	20% coinsurance after deductible is met	Not covered
Chemo/Radiation Therapy		
Office	20% coinsurance deductible does not apply	Not covered
Outpatient Hospital	20% coinsurance after deductible is met	Not covered
Skilled Nursing Care (in a facility) <i>Coverage is limited to 100 days per benefit period.</i>	20% coinsurance after deductible is met	Not covered
Inpatient Hospice	No charge after deductible is met	Not covered
Durable Medical Equipment	50% coinsurance after deductible is met	Not covered

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	\$150 person / \$300 family (does not apply to Tier 1 drugs)	\$150 person / \$300 family (does not apply to Tier 1 drugs)	Not covered
Pharmacy Out of Pocket Limit	Combined with In-Network medical out of pocket limit	Combined with In-Network medical out of pocket limit	Not covered
Prescription Drug Coverage Network: Rx Choice Tiered Network Drug List: <i>Select Drugs not included on the Select drug list will not be covered.</i>			
Day Supply Limits: Retail Pharmacy 30 day supply (cost shares noted below) Retail 90 Pharmacy 90 day supply (cost shares noted below) Home Delivery Pharmacy 90 day supply (maximum cost shares noted below) Maintenance medications are available through CarelonRx Mail (IngenioRx will become CarelonRx on January 1, 2023). You may get two 30-day supply fills of the same maintenance medication at a retail pharmacy. Prior to your 3rd fill, you must call us on the number on your ID card and tell us if you would like to keep getting your maintenance medications from a retail pharmacy or if you would like to use home delivery. If you do not contact us, you will pay the full retail cost of any maintenance medication until you inform us of your decision. Specialty Pharmacy 30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.			
Tier 1 - Typically Generic Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies.	\$10 copay per prescription, Pharmacy deductible does not apply (retail) and \$25 copay per prescription, Pharmacy deductible does not apply (home delivery)	\$20 copay per prescription, Pharmacy deductible does not apply (retail) and Not covered (home delivery)	Not covered (retail and home delivery)
Tier 2 - Typically Preferred Brand Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies.	\$50 copay per prescription after Pharmacy deductible is met (retail) and \$150 copay per prescription after Pharmacy deductible is met (home delivery)	\$60 copay per prescription after Pharmacy deductible is met (retail) and Not covered (home delivery)	Not covered (retail and home delivery)

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
<p>Tier 3 - Typically Non-Preferred Brand <i>Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies.</i></p>	<p>\$90 copay per prescription after Pharmacy deductible is met (retail) and \$270 copay per prescription after Pharmacy deductible is met (home delivery)</p>	<p>\$100 copay per prescription after Pharmacy deductible is met (retail) and Not covered (home delivery)</p>	<p>Not covered (retail and home delivery)</p>
<p>Tier 4 - Typically Specialty (brand and generic)</p>	<p>30% coinsurance up to \$250 per prescription after Pharmacy deductible is met (retail and home delivery)</p>	<p>40% coinsurance up to \$250 per prescription after Pharmacy deductible is met (retail) and Not covered (home delivery)</p>	<p>Not covered (retail and home delivery)</p>

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><i>This is a brief outline of your vision coverage. Not all cost shares for covered services are shown below. Benefits include coverage for member's choice of eyeglass lenses or contact lenses, but not both. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail.</i></p> <p><i>Only children's vision services count towards your out of pocket limit.</i></p>		
<p>Children's Vision Essential Health Benefits (up to age 19)</p>		
<p>Child Vision Deductible</p>	<p>Not Applicable</p>	<p>Not Applicable</p>
<p>Vision exam <i>Coverage for In-Network Providers is limited to 1 exam per benefit period.</i></p>	<p>No charge</p>	<p>Not covered</p>
<p>Frames <i>Coverage for In-Network Providers is limited to 1 unit per benefit period.</i></p>	<p>No charge</p>	<p>Not covered</p>
<p>Single Vision Lenses <i>Coverage for In-Network Providers is limited to 1 unit per benefit period.</i></p>	<p>No charge</p>	<p>Not covered</p>
<p>Bifocal Vision Lenses <i>Coverage for In-Network Providers is limited to 1 unit per benefit period.</i></p>	<p>No charge</p>	<p>Not covered</p>
<p>Trifocal Vision Lenses <i>Coverage for In-Network Providers is limited to 1 unit per benefit period.</i></p>	<p>No charge</p>	<p>Not covered</p>
<p>Elective contact lenses <i>Coverage for In-Network Providers is limited to 1 unit per benefit period.</i></p>	<p>No charge</p>	<p>Not covered</p>
<p>Non-Elective Contact Lenses <i>Coverage for In-Network Providers is limited to 1 unit per benefit period.</i></p>	<p>No charge</p>	<p>Not covered</p>
<p>Adult Vision (age 19 and older)</p>		
<p>Adult Vision Deductible</p>	<p>Not Applicable</p>	<p>Not Applicable</p>
<p>Vision exam <i>Coverage for In-Network Providers is limited to 1 exam per benefit period.</i></p>	<p>\$20 copay</p>	<p>Not covered</p>
<p>Frames</p>	<p>Not covered</p>	<p>Not covered</p>
<p>Single Vision Lenses</p>	<p>Not covered</p>	<p>Not covered</p>
<p>Bifocal Vision Lenses</p>	<p>Not covered</p>	<p>Not covered</p>
<p>Trifocal Vision Lenses</p>	<p>Not covered</p>	<p>Not covered</p>
<p>Elective contact lenses</p>	<p>Not covered</p>	<p>Not covered</p>
<p>Non-Elective Contact Lenses</p>	<p>Not covered</p>	<p>Not covered</p>

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><i>This is a brief outline of your dental coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/ Disclosure form/ Certificate. If there is a difference between this summary and either Evidence of Coverage/ Disclosure form/ Certificate, the Evidence of Coverage/ Disclosure form/ Certificate will prevail. Only children's dental services count towards your out of pocket limit.</i></p>		
<p>Children's Dental Essential Health Benefits Diagnostic and preventive <i>Coverage for In-Network Providers is limited to 1 visit per 6 months.</i></p>	0% coinsurance after deductible is met	Not covered
<p>Basic services</p>	50% coinsurance after deductible is met	Not covered
<p>Major services</p>	50% coinsurance after deductible is met	Not covered
<p>Medically Necessary Orthodontia services</p>	50% coinsurance after deductible is met	Not covered
<p>Cosmetic Orthodontia services</p>	Not covered	Not covered
<p>Deductible</p>	Combined with medical deductible	Not covered
<p>Adult Dental</p>		
<p>Diagnostic and preventive</p>	Not covered	Not covered
<p>Basic services</p>	Not covered	Not covered
<p>Major services</p>	Not covered	Not covered
<p>Deductible</p>	Not covered	Not covered
<p>Annual maximum</p>	Not covered	Not covered

Notes:

- Benefit period refers to calendar year.
- For additional information on this plan, please visit www.sbc.anthem.com to obtain a “Summary of Benefits and Coverage”.
- If services are rendered by a non-participating provider and your plan includes out of network benefits, you may be responsible for any difference between the covered plan payment and the actual non-participating provider’s charge.
- For plans with an office visit copay, the copay applies to the actual office visit and additional cost shares may apply for any other service performed in the office (i.e., X-ray, lab, surgery), after any applicable deductible.
- Certain services are subject to the utilization review program or precertification. Before scheduling services, the member must make sure utilization or precertification review is obtained. If utilization or precertification review is not obtained, benefits may be reduced or not paid according to the plan.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- Coverage includes standard fertility preservation services as a basic healthcare service including but are not limited to, injections, cryopreservation and storage for both male and female members when a medically necessary treatment may cause iatrogenic infertility. Member cost share for fertility preservation services is based on provider type and service rendered.
- This health plan includes an Employee Assistance Program (EAP) to support your emotional health and wellness with work life resources including one-on-one counseling by phone, in person and online, virtual visits through LiveHealth Online. Three visits are provided at no charge and 24/7, 365 days of support on the go.

Get help in your language

Language Assistance Services



Curious to know what all this says? We would be too. Here's the English version:

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish
IMPORTANTE: ¿Puede leer esta carta? De lo contrario, podemos hacer que alguien lo ayude a leerla. También puede recibir esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721. (TTY/TDD: 711)

Arabic
مهم: هل يمكنك قراءة هذه الرسالة؟ إذا لم تستطع، فيمكننا الاستعانة بشخص ما ليساعدك على قراءتها. كما يمكنك أيضًا الحصول على هذا الخطاب مكتوبًا بلغتك. للحصول على المساعدة المجانية، يُرجى الاتصال فورًا بالرقم 1-888-254-2721 (TTY/TDD: 711).

Armenian
ՈՒՇԱԳՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք ընթերցել այս նամակը: Եթե ոչ, մենք կարող ենք տրամադրել ինչ-որ մեկին, ով կօգնի Ձեզ՝ կարդալ այն: Կարող ենք նաև այս նամակը Ձեզ գրավոր տարբերակով տրամադրել: Անվճար օգնություն ստանալու համար կարող եք անհապաղ զանգահարել 1-888-254-2721 հեռախոսահամարով: (TTY/TDD: 711)

Chinese
重要事項：您能看懂這封信函嗎？如果您看不懂，我們能夠找人協助您。您有可能可以獲得以您的語言而寫的本信函。如需免費協助，請立即撥打1-888-254-2721。(TTY/TDD: 711)

Farsi
مهم: آیا می‌توانید این نامه را بخوانید؟ اگر نمی‌توانید، می‌توانیم شخصی را به شما معرفی کنیم تا در خواندن این نامه شما را کمک کند. همچنین می‌توانید این نامه را به صورت مکتوب به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، همین حالا با شماره 1-888-254-2721 تماس بگیرید. (TTY/TDD: 711)

Hindi
महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? अगर नहीं, तो हम आपको इसे पढ़ने में मदद करने के लिए किसी को उपलब्ध करा सकते हैं। आप यह पत्र अपनी भाषा में लिखवाने में भी सक्षम हो सकते हैं। निःशुल्क मदद के लिए, कृपया 1-888-254-2721 पर तुरंत कॉल करें। (TTY/TDD: 711)

Hmong
TSEEM CEEB: Koj puas muaj peev xwm nyeem tau daim ntawv no? Yog hais tias koj nyeem tsis tau, peb muaj peev xwm cia lwm tus pab nyeem rau koj mloog. Tsis tas li ntawd tej zaum koj kuj tseem yuav tau txais daim ntawv no sau ua koj hom lus thiab. Txog rau kev pab dawb, thov hu tam sim no rau tus xov tooj 1-888-254-2721. (TTY/TDD: 711)

Japanese

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重要：この書簡を読めますか？もし読めない場合には、内容を理解するための支援を受けることができます。また、この書簡を希望する言語で書いたもの入手することもできます。次の番号にいますぐ電話して、無料支援を受けてください。1-888-254-2721 (TTY/TDD: 711)

Khmer
សំខាន់៖ តើអ្នកអាចអានលិខិតនេះទេ? បើមិនអាចទេ យើងអាចឱ្យនរណាម្នាក់អានជូនអ្នក។ អ្នកក៏អាចទទួលលិខិតនេះដោយសរសេរជាភាសាបស្ចឹមផងដែរ។ ដើម្បីទទួលបានជំនួយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅលេខ 1-888-254-2721។ (TTY/TDD: 711)

Korean
중요: 이 서신을 읽으실 수 있으십니까? 읽으실 수 없을 경우 도움을 드릴 사람이 있습니다. 귀하가 사용하는 언어로 쓰여진 서신을 받으실 수도 있습니다. 무료 도움을 받으시려면 즉시 1-888-254-2721로 전화하십시오. (TTY/TDD: 711)

Punjabi
ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਕਿਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸੀਂ ਸਹਾਇਤਾ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵਧੀ ਪੜ੍ਹਾਏ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਫੌਰਨ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Russian
ВАЖНО. Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по номеру 1-888-254-2721. (TTY/TDD: 711)

Tagalog
MAHALAGA: Nababasa ba ninyo ang liham na ito? Kung hindi, may taong maaaring tumulong sa inyo sa pagbasa nito. Maaari ninyo ring makuha ang liham na ito nang nakasulat sa ginagamit ninyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

Thai
หมายเหตุสำคัญ: ท่านสามารถอ่านจดหมายฉบับนี้หรือไม่ หากท่านไม่สามารถอ่านจดหมายฉบับนี้ เราสามารถจัดหาเจ้าหน้าที่มาอ่านให้ท่านฟังได้ ท่านยังอาจให้เจ้าหน้าที่ช่วยเขียนจดหมายในภาษาของท่านอีกด้วย หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดโทรติดต่อที่หมายเลข 1-888-254-2721 (TTY/TDD: 711)

Vietnamese
QUAN TRỌNG: Quý vị có thể đọc thư này hay không? Nếu không, chúng tôi có thể bố trí người giúp quý vị đọc thư này. Quý vị cũng có thể nhận thư này bằng ngôn ngữ của quý vị. Để được giúp đỡ miễn phí, vui lòng gọi ngay số 1-888-254-2721. (TTY/TDD: 711)

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