

# Your summary of benefits

Anthem® Blue Cross

Your Contract Code: 5B12

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

Your Network: Select HMO

*This summary of benefits is a brief outline of coverage, designed to help you with the selection process. 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 formal 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 |
|---|---|--|
| <b>Overall Deductible</b><br><i>See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.</i>   | \$1,250 person /<br>\$2,500 family                | Not covered                            |
| <b>Out-of-Pocket Limit</b><br><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. See notes section for additional information regarding your out of pocket maximum.</i> | \$8,000 person /<br>\$16,000 family               | Not covered                            |
| <b>Preventive care/screening/immunization</b><br><i>In-network preventive care is not subject to deductible, if your plan has a deductible.</i>   | No charge   | Not covered                            |
| <b>Doctor Home and Office Services</b><br><br><b>Primary Care Visit to treat an injury or illness</b>   | \$35 copay per visit<br>deductible does not apply | Not covered                            |

# Your summary of benefits

| Covered Medical Benefits   | Cost if you use an In-Network Provider  | Cost if you use a Non-Network Provider                               |
|--|---|--|
| <b>Specialist Care Visit</b>   | \$60 copay per visit deductible does not apply  | Not covered  |
| <b>Prenatal Preventive Care</b>  | No charge   | Not covered  |
| <b>Post-natal Office Visit</b>   | \$35 copay per visit deductible does not apply  | Not covered  |
| <b>Other Practitioner Visits:</b><br>Retail Health Clinic Visit<br><br>Preferred On-line Visit<br><i>Includes Mental Health and Substance Use Disorder<br/>           Live Health Online is the preferred telehealth solution.<br/> <a href="http://www.livehealthonline.com">www.livehealthonline.com</a>.</i><br><br>Other Participating Provider On-line Visit<br><i>Includes Mental Health and Substance Use Disorder</i><br><br>Chiropractic/Manipulation Therapy<br><i>Coverage is limited to 20 visits per year. Applies to In-Network.<br/>           Limit is combined across professional visits and outpatient facilities.</i><br><br>Acupuncture | \$35 copay per visit deductible does not apply<br><br>No charge for the first 3 visits and then \$5 copay per visit deductible does not apply<br><br>\$35 copay per visit deductible does not apply<br><br>\$35 copay per visit deductible does not apply<br><br>\$35 copay per visit deductible does not apply | Not covered<br><br>Not covered<br><br>Not covered<br><br>Not covered |
| <b>Other Services in an Office:</b><br>Allergy Testing<br><br>Chemo/Radiation Therapy  | \$35 copay per visit deductible does not apply<br><br>20% coinsurance deductible does not apply   | Not covered<br><br>Not covered                                       |

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| Covered Medical Benefits   | Cost if you use an In-Network Provider  | Cost if you use a Non-Network Provider                    |
|--|---|---|
| Hemodialysis   | 20% coinsurance deductible does not apply   | Not covered   |
| Drugs Administered in the Office<br><i>For the drugs itself dispensed in the office through infusion/injection.</i>  | 20% coinsurance deductible does not apply   | Not covered   |
| <b>Diagnostic Services</b><br><br><b>Lab:</b><br><br>Office<br><i>Office Cost Share applies only when Freestanding/Reference Labs are not used.</i><br><br>Freestanding Lab/Reference Lab<br><br>Outpatient Hospital | <br><br>\$35 copay per service deductible does not apply<br><br>\$35 copay per visit deductible does not apply<br><br>20% coinsurance after deductible is met | <br><br>Not covered<br><br>Not covered<br><br>Not covered |
| <b>X-Ray:</b><br><br>Office<br><br>Outpatient Hospital   | <br>\$60 copay per service deductible does not apply<br><br>20% coinsurance after deductible is met   | <br>Not covered<br><br>Not covered                        |
| <b>Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):</b><br><br>Office<br><br>Outpatient Hospital  | <br>\$125 copay per procedure deductible does not apply<br><br>\$250 copay per procedure after deductible is met  | <br>Not covered<br><br>Not covered                        |

# Your summary of benefits

| Covered Medical Benefits  | Cost if you use an In-Network Provider   | Cost if you use a Non-Network Provider             |
|---|--|--|
| <b>Emergency and Urgent Care</b><br><b>Urgent Care (Office Setting)</b>   | \$35 copay per visit<br>deductible does not apply  | Not covered  |
| <b>Emergency Room Facility Services</b><br><i>Emergency Room copay is waived if directly admitted to the hospital.</i><br><br><b>Emergency Room Doctor and Other Services</b> | \$300 copay per visit<br>and 20% coinsurance<br>after deductible is met<br><br>No charge | Covered as In-Network<br><br>Covered as In-Network |
| <b>Ambulance Transportation</b>   | 20% coinsurance<br>after deductible is met   | Covered as In-Network                              |
| <b>Outpatient Mental Health and Substance Use Disorder</b><br><b>Doctor Office Visit</b><br><br><b>Facility visit:</b><br>Facility Fees<br><br>Doctor Services                | \$35 copay per visit<br>deductible does not apply<br><br>No charge<br><br>No charge      | Not covered<br><br>Not covered<br><br>Not covered  |
| <b>Outpatient Surgery</b><br><b>Facility Fees:</b><br>Hospital<br><br><b>Doctor and Other Services:</b>   | 20% coinsurance<br>after deductible is met   | Not covered  |

# Your summary of benefits

| Covered Medical Benefits  | Cost if you use an In-Network Provider  | Cost if you use a Non-Network Provider |
|---|---|--|
| Hospital  | No charge   | Not covered                            |
| <b>Hospital Stay (all inpatient stays including Maternity, Mental / Behavioral Health, and Substance Abuse)</b><br><br><b>Facility fees (for example, room &amp; board)</b><br><i>Coverage for Skilled Nursing and Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is limited to 100 days combined per benefit period. Applies to In-Network.</i><br><br><b>Doctor and other services</b> | 20% coinsurance after deductible is met<br><br>No charge                                      | Not covered<br><br>Not covered         |
| <b>Recovery &amp; Rehabilitation</b><br><br><b>Home Health Care</b><br><i>Coverage is limited to 100 visits per year. Applies to In-Network. Limit does not apply to separate Physical or Occupational or Speech Therapy limits, when performed as part of Home Health. A visit equals 4 hours or less of care. Limits are combined for home health care and private duty nursing.</i>  | \$60 copay per visit deductible does not apply  | Not covered                            |
| <b>Rehabilitation services (for example, physical/speech/occupational therapy):</b><br><br>Office<br><br>Outpatient Hospital  | \$35 copay per visit deductible does not apply<br><br>20% coinsurance after deductible is met | Not covered<br><br>Not covered         |
| <b>Habilitation services (for example, physical/speech/occupational therapy):</b><br><br>Office<br><br>Outpatient Hospital  | \$35 copay per visit deductible does not apply<br><br>20% coinsurance after deductible is met | Not covered<br><br>Not covered         |

# Your summary of benefits

| Covered Medical Benefits   | Cost if you use an In-Network Provider   | Cost if you use a Non-Network Provider |
|--|--|--|
| <p><b>Cardiac rehabilitation</b></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><b>Skilled Nursing Care (in a facility)</b><br/> <i>Coverage for Skilled Nursing and Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is limited to 100 days combined per benefit period. Applies to In-Network.</i></p> | <p>20% coinsurance after deductible is met</p>   | <p>Not covered</p>                     |
| <p><b>Hospice</b></p>  | <p>0% coinsurance after deductible is met</p>  | <p>Not covered</p>                     |
| <p><b>Durable Medical Equipment</b></p>  | <p>50% coinsurance after deductible is met</p>   | <p>Not covered</p>                     |

# Your summary of benefits

| Covered Prescription Drug Benefits   | Cost if you use an In-Network Provider   | Cost if you use a Non-Network Provider |
|--|--|--|
| <p><b>Pharmacy Deductible</b></p> <p><b>Additional deductible:</b><br/><i>Applies to Tier 2 , Tier 3 and Tier 4 Prescription Drugs for In-Network Providers.</i></p>   | \$100 person / \$200 family  | Not covered                            |
| <p><b>Pharmacy Out of Pocket</b></p>   | Combined with medical out of pocket maximum  | Not covered                            |
| <p><b>Prescription Drug Coverage</b><br/><i>Select Drug List</i><br/><i>This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies.</i></p>   |  |  |
| <p><b>Tier 1 - Typically Generic</b><br/><i>Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.</i></p>         | \$15 copay per prescription, Pharmacy deductible does not apply (retail) and \$38 copay per prescription, Pharmacy deductible does not apply (home delivery) | Not covered (retail and home delivery) |
| <p><b>Tier 2 – Typically Preferred Brand</b><br/><i>Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.</i></p> | \$40 copay per prescription after Pharmacy deductible is met (retail) and \$120 copay per prescription after Pharmacy deductible is met (home delivery)      | Not covered (retail and home delivery) |
| <p><b>Tier 3 - Typically Non-Preferred Brand</b></p>   | \$80 copay per prescription after Pharmacy   | Not covered (retail and home delivery) |

# Your summary of benefits

| Covered Prescription Drug Benefits  | Cost if you use an In-Network Provider  | Cost if you use a Non-Network Provider        |
|---|---|---|
| <p><i>Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.</i></p>    | <p>deductible is met (retail) and \$240 copay per prescription after Pharmacy deductible is met (home delivery)</p> |   |
| <p><b>Tier 4 - Typically Specialty (brand and generic)</b><br/> <i>Covers up to a 30 day supply (retail pharmacy). Covers up to a 30 day supply (home delivery program). No coverage for non-formulary drugs.</i></p> | <p>30% coinsurance up to \$250 per prescription after Pharmacy deductible is met (retail and home delivery)</p>     | <p>Not covered (retail and home delivery)</p> |



# Your summary of benefits

| 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><b>Children's Vision Essential Health Benefits (up to age 19)</b></p> <p><b>Child Vision Deductible</b></p> <p><b>Vision exam</b><br/><i>Coverage for In-Network Providers is limited to 1 exam per benefit period.</i></p>   | <p>Not Applicable<br/>No charge</p>    | <p>Not Applicable<br/>Not covered</p>  |
| <p><b>Frames</b><br/><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><b>Single Vision Lenses</b><br/><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><b>Bifocal Vision Lenses</b><br/><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><b>Trifocal Vision Lenses</b><br/><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><b>Elective contact lenses</b><br/><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><b>Non-Elective Contact Lenses</b><br/><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><b>Adult Vision (age 19 and older)</b></p> <p><b>Adult Vision Deductible</b></p> <p><b>Vision exam</b><br/><i>Coverage for In-Network Providers is limited to 1 exam per benefit period.</i></p>  | <p>Not Applicable<br/>\$20 copay</p>   | <p>Not Applicable<br/>Not covered</p>  |
| <p><b>Frames</b></p>   | <p>Not covered</p>                     | <p>Not covered</p>                     |
| <p><b>Single Vision Lenses</b></p>   | <p>Not covered</p>                     | <p>Not covered</p>                     |

# Your summary of benefits

| Covered Vision Benefits            | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|------------------------------------|--|--|
| <b>Bifocal Vision Lenses</b>       | Not covered                            | Not covered                            |
| <b>Trifocal Vision Lenses</b>      | Not covered                            | Not covered                            |
| <b>Elective contact lenses</b>     | Not covered                            | Not covered                            |
| <b>Non-Elective Contact Lenses</b> | Not covered                            | Not covered                            |

# Your summary of benefits

| 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> |   |  |
| <b>Children's Dental Essential Health Benefits</b><br><b>Diagnostic and preventive</b><br><i>Coverage for In-Network Providers is limited to 1 visit per 6 months.</i>   | 0% coinsurance after deductible is met  | Not covered                            |
| <b>Basic services</b>  | 50% coinsurance after deductible is met | Not covered                            |
| <b>Major services</b>  | 50% coinsurance after deductible is met | Not covered                            |
| <b>Medically Necessary Orthodontia services</b>  | 50% coinsurance after deductible is met | Not covered                            |
| <b>Cosmetic Orthodontia services</b>   | Not covered                             | Not covered                            |
| <b>Deductible</b>  | Combined with medical deductible        | Not covered                            |
| <b>Adult Dental</b>  |   |  |
| <b>Diagnostic and preventive</b>   | Not covered                             | Not covered                            |
| <b>Basic services</b>  | Not covered                             | Not covered                            |
| <b>Major services</b>  | Not covered                             | Not covered                            |
| <b>Deductible</b>  | Not covered                             | Not covered                            |
| <b>Annual maximum</b>  | Not covered                             | Not covered                            |

# Your summary of benefits

## Notes:

- The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.
- If your plan includes a hospital stay copay and you are readmitted within 72 hours of a prior admission for the same diagnosis, your hospital stay copay for your readmission is waived.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- For additional information on this plan, please visit [www.sbc.anthem.com](http://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.
- Your plan requires selection of a Primary Care Physician. Your plan requires a referral from your Primary Care Physician for select covered services.
- Benefit period refers to calendar year.
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- Your copays, coinsurance and deductible count toward your out of pocket amount.
- Your plan requires selection of a Primary Care Physician (PCP). Choosing a PCP is an important decision, call Member Services at the number on your Anthem ID card and we'll help you pick a doctor.
- All medical and pharmacy deductibles, copayments and coinsurance apply to the out of pocket maximum.
- This health plan includes an Employee Assistance Program (EAP) with myStrength to support your emotional health and wellness with 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

ՌԻՇԱԴՐՈՒԹՅՈՒՆ. 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

Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

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។ អ្នកក៏អាចទទួលបានលិខិតនេះដោយសរសេរជាភាសាបស្ចឹមផងដែរ។ 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 ਕੇ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਕਿਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸੀਂ ਸ਼ਾਇਦ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵੱਖੀ ਪੜ੍ਹਾ 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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That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence  
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