

# Your summary of benefits

Anthem® Blue Cross

Your Contract Code: 3KG5

Your Plan: Anthem Silver PPO 50/2000/40%

Your Network: Prudent Buyer PPO

*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.*

| 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>   | \$2,000 person /<br>\$4,000 family             | \$4,000 person /<br>\$8,000 family      |
| <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> | \$7,900 person /<br>\$15,800 family            | \$15,800 person /<br>\$31,600 family    |
| <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                                      | 50% coinsurance after deductible is met |
| <b>Doctor Home and Office Services</b><br><br><b>Primary Care Visit to treat an injury or illness</b>   | \$50 copay per visit deductible does not apply | 50% coinsurance after deductible is met |
| <b>Specialist Care Visit</b>  | \$85 copay per visit deductible does not apply | 50% coinsurance after deductible is met |
| <b>Prenatal Preventive Care</b>   | No charge                                      | 50% coinsurance after deductible is met |

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| Covered Medical Benefits   | Cost if you use an In-Network Provider  | Cost if you use a Non-Network Provider   |
|--|---|--|
| <b>Post-natal Office Visit</b>   | \$50 copay per visit deductible does not apply  | 50% coinsurance after deductible is met  |
| <b>Other Practitioner Visits:</b><br>Retail Health Clinic Visit<br><br>On-line Visit<br><i>Live Health Online is the preferred telehealth solutions (<a href="http://www.livehealthonline.com">www.livehealthonline.com</a>)</i><br><br>Chiropractic/Manipulation Therapy<br><i>Coverage is limited to 20 visits per year. Applies to In-Network. Visit limits are combined both across outpatient and other professional visits.</i><br><br>Acupuncture | \$35 copay per visit deductible does not apply<br><br>No charge for the first 3 visits and then \$15 copay per visit medical deductible does not apply<br><br>50% coinsurance deductible does not apply<br><br>\$50 copay per visit deductible does not apply | 50% coinsurance after deductible is met<br><br>50% coinsurance after deductible is met<br><br>Not covered<br><br>Not covered   |
| <b>Other Services in an Office:</b><br>Allergy Testing<br><br>Chemo/Radiation Therapy<br><br>Hemodialysis<br><br>Drugs Administered in the Office<br><i>For the drugs itself dispensed in the office through infusion/injection.</i>   | 40% coinsurance after deductible is met<br><br>40% coinsurance after deductible is met<br><br>40% coinsurance after deductible is met<br><br>40% coinsurance after deductible is met  | 50% coinsurance after deductible is met<br><br>50% coinsurance after deductible is met<br><br>50% coinsurance after deductible is met<br><br>50% coinsurance after deductible is met |

# 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>Diagnostic Services</b></p> <p><b>Lab:</b></p> <p>Office</p> <p>Outpatient Hospital<br/><i>Anthem's maximum payment is up to \$380 per service for Non-Network Providers.</i></p>  | <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>                               | <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> |
| <p><b>X-Ray:</b></p> <p>Office</p> <p>Outpatient Hospital<br/><i>Anthem's maximum payment is up to \$380 per service for Non-Network Providers.</i></p>  | <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>                               | <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> |
| <p><b>Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):</b></p> <p>Office<br/><i>Anthem's maximum payment is up to \$800 per service for Non-Network Providers.</i></p> <p>Outpatient Hospital<br/><i>Anthem's maximum payment is up to \$380 per admission for non-network providers.</i></p> | <p>40% coinsurance after deductible is met</p> <p>40% coinsurance and \$100 copay per procedure after deductible is met</p> | <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> |
| <p><b>Emergency and Urgent Care</b></p> <p><b>Urgent Care (Office Setting)</b></p>   | <p>\$85 copay per visit deductible does not apply</p>   | <p>50% coinsurance after deductible is met</p>  |
| <p><b>Emergency Room Facility Services</b><br/><i>Copay waived if admitted.</i></p>  | <p>\$350 copay per visit and 40% coinsurance after deductible is met</p>  | <p>Covered as In-Network</p>  |

# 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>Emergency Room Doctor and Other Services</b></p>  | <p>40% coinsurance after deductible is met</p>  | <p>Covered as In-Network</p>   |
| <p><b>Ambulance Transportation</b><br/> <i>Non-emergency, Non-Network air ambulance services are limited to Anthem maximum payment of \$50,000 per trip.</i></p>  | <p>40% coinsurance after deductible is met</p>  | <p>Covered as In-Network</p>   |
| <p><b>Outpatient Mental Health and Substance Use Disorder</b></p> <p><b>Doctor Office Visit and Online Visit</b></p> <p><b>Facility visit:</b></p> <p>    Facility Fees</p> <p>    Doctor Services</p>                                    | <p>\$50 copay per visit deductible does not apply</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> | <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> |
| <p><b>Outpatient Surgery</b></p> <p><b>Facility Fees:</b></p> <p>    Hospital<br/> <i>Anthem's maximum payment is up to \$380 per service for Non-Network Providers.</i></p> <p><b>Doctor and Other Services:</b></p> <p>    Hospital</p> | <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>   | <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>  |

# 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>Hospital Stay (all inpatient stays including Maternity, Mental / Behavioral Health, and Substance Abuse)</b></p> <p><b>Facility fees (for example, room &amp; board)</b><br/> <i>Coverage for Inpatient Rehabilitation and Skilled Nursing services is limited to 100 days combined per benefit period. Anthem's maximum payment is up to \$650 per day for non-network providers. Limit is combined In-Network and Non-Network.</i></p> <p><b>Doctor and other services</b></p>   | <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> | <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> |
| <p><b>Recovery &amp; Rehabilitation</b></p> <p><b>Home Health Care</b><br/> <i>Coverage is limited to 100 visits per year. Limit is combined In-Network and Non-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. Anthem's maximum payment is up to \$75 per visit for non-network.</i></p> | <p>40% coinsurance after deductible is met</p>  | <p>50% coinsurance after deductible is met</p>  |
| <p><b>Rehabilitation services (for example, physical/speech/occupational therapy):</b></p> <p>Office</p> <p>Outpatient Hospital<br/> <i>Limit is combined In-Network and Non-Network across all outpatient settings. Anthem's maximum payment is up to \$380 per admission for non-network providers.</i></p>  | <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> | <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> |
| <p><b>Habilitation services (for example, physical/speech/occupational therapy):</b></p> <p>Office</p> <p>Outpatient Hospital<br/> <i>Anthem's maximum payment is up to \$380 per admission for non-network providers.</i></p>   | <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> | <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> |

# 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<br/><i>Anthem's maximum payment is up to \$380 per admission for non-network providers.</i></p>   | <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> | <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> |
| <p><b>Skilled Nursing Care (in a facility)</b><br/><i>Coverage for Inpatient rehabilitation and skilled nursing services is limited to 100 days combined per benefit period. Limit is combined In-Network and Non-Network. Anthem's maximum payment is up to \$150 per day for admissions to non-network providers.</i></p> | <p>40% coinsurance after deductible is met</p>  | <p>50% coinsurance after deductible is met</p>  |
| <p><b>Hospice</b></p>   | <p>0% coinsurance after deductible is met</p>   | <p>50% coinsurance after deductible is met</p>  |
| <p><b>Durable Medical Equipment</b></p>   | <p>50% coinsurance after deductible is met</p>  | <p>50% coinsurance after deductible is met</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 |
|--|--|--|
| <b>Pharmacy Deductible</b>   | \$150 person / \$300 family  | Not covered                            |
| <b>Pharmacy Out of Pocket</b>  | Combined with medical out of pocket maximum  | Not covered                            |
| <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>  |  |  |
| <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>             | \$20 copay per prescription, Pharmacy deductible does not apply (retail) and \$50 copay per prescription, Pharmacy deductible does not apply (home delivery) | Not covered (retail and home delivery) |
| <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>     | \$55 copay per prescription after Pharmacy deductible is met (retail) and \$165 copay per prescription after Pharmacy deductible is met (home delivery)      | Not covered (retail and home delivery) |
| <b>Tier 3 - Typically Non-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> | \$95 copay per prescription after Pharmacy deductible is met (retail) and \$285  | 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 |
|---|--|--|
|   | copay per prescription after Pharmacy deductible is met (home delivery)                                  |  |
| <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> | 30% coinsurance up to \$250 per prescription after Pharmacy deductible is met (retail and home delivery) | Not covered (retail and home delivery) |



# 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 and Non-Network Providers is limited to 1 exam per benefit period.</i></p>   | <p>Not Applicable<br/>\$0 copay</p>    | <p>Not Applicable<br/>\$0 copayment up to plan's Maximum Allowed Amount</p> |
| <p><b>Frames</b><br/><i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.</i></p>   | <p>No charge</p>                       | <p>\$0 copayment up to plan's Maximum Allowed Amount</p>                    |
| <p><b>Lenses</b><br/><i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.</i></p>   | <p>\$0 copay</p>                       | <p>\$0 copayment up to plan's Maximum Allowed Amount</p>                    |
| <p><b>Elective contact lenses</b><br/><i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.</i></p>  | <p>No charge</p>                       | <p>\$0 copayment up to plan's Maximum Allowed Amount</p>                    |
| <p><b>Non-Elective Contact Lenses</b><br/><i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.</i></p>  | <p>No charge</p>                       | <p>\$0 copayment up to plan's Maximum Allowed Amount</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 and Non-Network Providers is limited to 1 exam per benefit period.</i></p>  | <p>Not Applicable<br/>\$20 copay</p>   | <p>Not Applicable<br/>Reimbursed Up to \$30</p>                             |
| <p><b>Frames</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>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.</i></p> <p><i>Only children's dental services count towards your out of pocket limit.</i></p> |   |   |
| <p><b>Children's Dental Essential Health Benefits</b><br/> <b>Diagnostic and preventive</b><br/> <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 visit per 6 months.</i></p>  | No charge                               | No charge                               |
| <p><b>Basic services</b></p>   | 50% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| <p><b>Major services</b></p>   | 50% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| <p><b>Medically Necessary Orthodontia services</b></p>   | 50% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| <p><b>Cosmetic Orthodontia services</b></p>  | Not covered                             | Not covered                             |
| <p><b>Deductible</b></p>   | Combined with medical deductible        | Combined with medical deductible        |
| <p><b>Adult Dental</b></p>   |   |   |
| <p><b>Diagnostic and preventive</b></p>  | Not covered                             | Not covered                             |
| <p><b>Basic services</b></p>   | Not covered                             | Not covered                             |
| <p><b>Major services</b></p>   | Not covered                             | Not covered                             |
| <p><b>Deductible</b></p>   | Not covered                             | Not covered                             |
| <p><b>Annual maximum</b></p>   | Not covered                             | Not covered                             |

# Your summary of benefits

## Notes:

- For additional information on this plan, please visit [www.sbc.anthem.com](http://www.sbc.anthem.com) to obtain a “Summary of Benefit 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 providers charge.
- 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 for Non-emergency ambulance service for Non-Network Providers is limited to \$50,000 maximum benefit per occurrence.
- 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.
- For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to [ca.sgplans.anthem.com/ca/le](http://ca.sgplans.anthem.com/ca/le)
- 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 readmitted within 72 hours for the same diagnosis of the previous discharge, no additional facility copayment is required. If transferred between facilities, only one copayment will apply.
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- The family deductible and out-of-pocket maximum are embedded indicating the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; additionally, 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.
- Your coinsurance, copays and deductible count toward your out of pocket amount.

# 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

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. 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)

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Japanese

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を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 យើងអាចឱ្យនរណាម្នាក់អានជំនួយអ្នក។ អ្នកក៏អាចទទួលបានលិខិតនេះដោយសេរីដោយសេរីជាភាសាបេសអ្នកផងដែរ។ 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

ਸ਼ੁੱਠੀ ਸ਼ੁੱਠੀ: ਕੀ ਤੁਸੀਂ ਇਹ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸਨੂੰ ਤੁਹਾਨੂੰ ਸਮਝਾਉਣ ਲਈ ਮਦਦ ਕਰ ਸਕਦੇ ਹਾਂ। ਜੇ ਤੁਸੀਂ ਇਸਨੂੰ ਆਪਣੀ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਪੜ੍ਹਨਾ ਚਾਹੁੰਦੇ ਹੋ, ਤਾਂ ਸਾਨੂੰ ਦੱਸੋ। ਮੁਫਤ ਮਦਦ ਲਈ 1-888-254-2721 'ਤੇ ਸਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਦੱਸੋ।

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

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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