

# Your summary of benefits



Anthem® Blue Cross

Your 2024 Contract Code: 9B1C

Your Plan: Anthem Silver Select HMO 60/2500/45% WH

Your Network: 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 health and substance use disorders. Benefits are subject to all terms, conditions, limitations, and exclusions of the EOC.*

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
<b>Primary Care, and medical services for urgent/acute care</b>	No charge
<b>Mental Health &amp; Substance Use Disorder Services</b>	No charge
<b>Specialist care</b>	\$95 copay per visit medical deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Overall Deductible</b> <i>Your plan applies a separate Pharmacy Deductible to prescription drugs obtained at a pharmacy. See the Covered Prescription Drug Benefits section.</i>	\$2,500 person / \$5,000 family	Not covered
<b>Overall Out-of-Pocket Limit</b> <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>	\$9,100 person / \$18,200 family	Not covered

*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.*

*Your copays, coinsurance and deductible count toward your out-of-pocket limit. However, member cost sharing for the following service(s) do not apply toward the out-of-pocket limit: adult vision.*

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Doctor Visits (virtual and office)</b> <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>		
<b>Primary Care (PCP) and Mental Health and Substance Use Disorder Services</b> <i>virtual and office</i>	\$60 copay per visit medical deductible does not apply	Not covered
<b>Specialist Care</b> <i>virtual and office</i>	\$95 copay per visit medical deductible does not apply	Not covered
<b>Other Practitioner Visits</b>		
Routine Maternity Care	No charge	Not covered
Prenatal	No charge	Not covered
Postnatal	\$60 copay per visit medical deductible does not apply	Not covered
Retail Health Clinic Visit	\$60 copay per visit medical deductible does not apply	Not covered
Chiropractic/Manipulation Therapy <i>Coverage is limited to 30 visits per year.</i>	\$15 copay per visit medical deductible does not apply	Not covered
Acupuncture	\$60 copay per visit medical deductible does not apply	Not covered
<b>Other Services in an Office</b>		
Allergy Testing	\$60 copay per visit medical deductible does not apply	Not covered
Prescription Drugs - Dispensed in the office <i>For the drugs itself dispensed in the office through infusion/injection.</i>	45% coinsurance medical deductible does not apply	Not covered
Surgery	\$95 copay per surgery medical deductible does not apply	Not covered
<b>Preventive care/screenings/immunizations</b>	No charge	Not covered
<b>Preventive care for Chronic Conditions</b> <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><b><u>Diagnostic Services</u></b></p> <p><b>Lab</b></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>\$20 copay per visit medical deductible does not apply</p> <p>No charge</p> <p>45% coinsurance after medical deductible is met</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p><b>X-Ray</b></p> <p>Office</p> <p>Freestanding Radiology Center</p> <p>Outpatient Hospital</p>	<p>\$20 copay per visit medical deductible does not apply</p> <p>\$20 copay per visit medical deductible does not apply</p> <p>45% coinsurance after medical deductible is met</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p><b>Advanced Diagnostic Imaging</b> - 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 medical deductible does not apply</p> <p>\$200 copay per visit medical deductible does not apply</p> <p>\$350 copay per visit after medical deductible is met</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p><b><u>Emergency and Urgent Care</u></b></p> <p><b>Urgent Care (Office Setting)</b></p> <p><b>Emergency Room Facility Services</b> <i>Your copay will be waived if admitted.</i></p>	<p>\$60 copay per visit medical deductible does not apply</p> <p>\$350 copay per visit and 45% coinsurance</p>	<p>Covered as In-Network</p> <p>Covered as In-Network</p>

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><b>Ambulance Transportation</b>  <i>Authorized Non-Network non-emergency ambulance services are limited to an Anthem maximum payment of \$50,000 per trip.</i></p>	<p>after medical deductible is met</p> <p>No charge</p> <p>45% coinsurance after medical deductible is met</p>	<p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p><b><u>Outpatient Mental Health and Substance Use Disorder Services at a Facility</u></b></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><b><u>Outpatient Surgery</u></b></p> <p><b>Facility Fees</b></p> <p>Hospital</p> <p>Ambulatory Surgical Center</p> <p><b>Physician and other services including surgeon fees</b></p> <p>Hospital</p> <p>Ambulatory Surgical Center</p>	<p>45% coinsurance after medical deductible is met</p> <p>\$600 copay per visit after medical 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>
<p><b><u>Hospital Stay (all Inpatient stays including Maternity, Mental Health and Substance Use Disorder Services)</u></b></p> <p>Facility fees (for example, room &amp; board)</p> <p>Physician and other services including surgeon fees</p>	<p>45% coinsurance after medical deductible is met</p> <p>No charge</p>	<p>Not covered</p> <p>Not covered</p>
<p><b>Home Health Care</b></p>	<p>\$95 copay per visit  medical 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
<i>Home health visits are limited to 100 visits per benefit period. 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><b>Rehabilitation services (for example, physical/speech/occupational therapy)</b></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$60 copay per visit medical deductible does not apply</p> <p>45% coinsurance after medical deductible is met</p>	<p>Not covered</p> <p>Not covered</p>
<p><b>Habilitation services (for example, physical/speech/occupational therapy)</b></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$60 copay per visit medical deductible does not apply</p> <p>45% coinsurance after medical deductible is met</p>	<p>Not covered</p> <p>Not covered</p>
<p><b>Pulmonary rehabilitation</b></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$60 copay per visit medical deductible does not apply</p> <p>45% coinsurance after medical deductible is met</p>	<p>Not covered</p> <p>Not covered</p>
<p><b>Cardiac rehabilitation</b></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$60 copay per visit medical deductible does not apply</p> <p>45% coinsurance after medical deductible is met</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
<b>Dialysis/Hemodialysis</b>  Office  Outpatient Hospital	45% coinsurance medical deductible does not apply  45% coinsurance after medical deductible is met	Not covered  Not covered
<b>Chemo/Radiation Therapy</b>  Office  Outpatient Hospital	45% coinsurance medical deductible does not apply  45% coinsurance after medical deductible is met	Not covered  Not covered
<b>Skilled Nursing Care (in a facility)</b> <i>Coverage is limited to 100 days per benefit period.</i>	45% coinsurance after medical deductible is met	Not covered
<b>Inpatient Hospice</b>	No charge after medical deductible is met	Not covered
<b>Durable Medical Equipment</b>	50% coinsurance after medical 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
<b>Pharmacy Deductible</b>	\$200 person / \$400 family (does not apply to Tier 1 drugs)	\$200 person / \$400 family (does not apply to Tier 1 drugs)	Not covered
<b>Pharmacy Out of Pocket Limit</b>	Combined with In-Network medical out of pocket limit	Combined with In-Network medical out of pocket limit	Not covered
<p><b>Prescription Drug Coverage</b>  <b>Network: Rx Choice Tiered Network</b>  <b>Drug List: Select</b> Drugs not included on the Select drug list will not be covered. Prescription Drugs that we are required to cover by federal law under the "Preventive Care" benefit will be covered with no deductible, copayments or coinsurance when you use an In-Network Pharmacy.</p>			
<p><b>Day Supply Limits:</b>  <b>Retail Pharmacy</b> 30 day supply (cost shares noted below)  <b>Retail 90 Pharmacy</b> 90 day supply (cost shares noted below)  <b>Home Delivery Pharmacy</b> 90 day supply (maximum cost shares noted below). Maintenance medications are available through CarelonRx Pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.  <b>Specialty Pharmacy</b> 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.</p>			
<p><b>Tier 1 - Typically Generic</b>  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.</p>	<p>\$10 copay per prescription, Pharmacy deductible does not apply (retail) and \$20 copay per prescription, Pharmacy deductible does not apply (home delivery)</p>	<p>\$20 copay per prescription, Pharmacy deductible does not apply (retail) and Not covered (home delivery)</p>	<p>Not covered (retail and home delivery)</p>
<p><b>Tier 2 - Typically Preferred Brand</b>  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.</p>	<p>\$70 copay per prescription after Pharmacy deductible is met (retail) and \$175 copay per prescription after Pharmacy deductible is met (home delivery)</p>	<p>\$80 copay per prescription after Pharmacy deductible is met (retail) and Not covered (home delivery)</p>	<p>Not covered (retail and home delivery)</p>

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><b>Tier 3 - Typically Non-Preferred Brand</b>  <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>\$110 copay per prescription after Pharmacy deductible is met (retail) and \$275 copay per prescription after Pharmacy deductible is met (home delivery)</p>	<p>\$120 copay per prescription after Pharmacy deductible is met (retail) and Not covered (home delivery)</p>	<p>Not covered (retail and home delivery)</p>
<p><b>Tier 4 - Typically Specialty (brand and generic)</b></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. 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>  <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period.</i></p>	<p>Not Applicable  No charge</p>	<p>Not Applicable  \$0 copayment up to plan's Maximum Allowed Amount</p>
<p><b>Frames</b>  <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>Single Vision Lenses</b>  <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>Bifocal Vision Lenses</b>  <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>Trifocal Vision Lenses</b>  <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>Elective contact lenses</b>  <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>  <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>  <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period.</i></p>	<p>Not Applicable  \$20 copay</p>	<p>Not Applicable  Reimbursed Up to \$30</p>
<p><b>Frames</b>  <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit every 2 benefit periods.</i></p>	<p>\$130 Allowance</p>	<p>Reimbursed Up to \$45</p>

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b>Single Vision Lenses</b>  <i>Coverage for Eye Glass Lenses or Contact Lens In-Network Providers and Non-Network Providers is limited to 1 unit every 2 benefit periods.</i></p>	\$20 copay	Reimbursed Up to \$25
<p><b>Bifocal Vision Lenses</b>  <i>Coverage for Eye Glass Lenses or Contact Lens In-Network Providers and Non-Network Providers is limited to 1 unit every 2 benefit periods.</i></p>	\$20 copay	Reimbursed Up to \$40
<p><b>Trifocal Vision Lenses</b>  <i>Coverage for Eye Glass Lenses or Contact Lens In-Network Providers and Non-Network Providers is limited to 1 unit every 2 benefit periods.</i></p>	\$20 copay	Reimbursed Up to \$55
<p><b>Elective contact lenses</b>  <i>Coverage for Eye Glass Lenses or Contact Lens In-Network Providers and Non-Network Providers is limited to 1 unit every 2 benefit periods.</i></p>	\$80 Allowance	Reimbursed Up to \$60
<p><b>Non-Elective Contact Lenses</b>  <i>Coverage for Eye Glass Lenses or Contact Lens In-Network Providers and Non-Network Providers is limited to 1 unit every 2 benefit periods.</i></p>	No charge	Reimbursed Up to \$210

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><b>Children's Dental Essential Health Benefits</b>  <b>Diagnostic and preventive</b>  <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>	20% coinsurance after dental deductible is met	20% coinsurance after dental deductible is met
<p><b>Major services</b></p>	50% coinsurance after dental deductible is met	50% coinsurance after dental deductible is met
<p><b>Medically Necessary Orthodontia services</b></p>	50% coinsurance after dental deductible is met	50% coinsurance after dental deductible is met
<p><b>Cosmetic Orthodontia services</b></p>	Not covered	Not covered
<p><b>Deductible</b></p>	\$50	\$50
<p><b>Adult Dental</b></p>		
<p><b>Diagnostic and preventive</b>  <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 visits per 6 months.</i></p>	No charge	No charge
<p><b>Basic services</b></p>	20% coinsurance after dental deductible is met	20% coinsurance after dental deductible is met
<p><b>Major services</b></p>	50% coinsurance after dental deductible is met	50% coinsurance after dental deductible is met
<p><b>Deductible</b></p>	\$50	\$50
<p><b>Annual maximum</b></p>	\$1,000	\$1,000

**Notes:**

- Benefit period refers to calendar year.
- 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.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.
- 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.
- 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 are available through LiveHealth Online and Talkspace. Three visits are provided at no charge and 24/7, 365 days of support on the go.

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Questions: (833) 913-2234 or visit us at [www.anthem.com/ca](http://www.anthem.com/ca)

CA/SG/Anthem Silver Select HMO 60/2500/45% WH/9B1C/01-01-2024

## 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

ՈՒՇԳՂԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք ընթերցել այս նամակը: Եթե ոչ, մենք կարող ենք տրամադրել ինչ-որ մեկին, ով կօգնի Ձեզ՝ կարդալ այն: Կարող եք 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។ អ្នកក៏អាចទទួលលិខិតនេះដោយសរសេរជាភាសាបស្ចុជ្ជសម្រាប់អ្នកផងដែរ។ 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 ਪੜ੍ਹ 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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