




The Summary of Benefits and Coverage (SBC) document will help you choose a health **plan**. The SBC shows you how you and the **plan** would share the cost for covered health care services. **NOTE: Information about the cost of this **plan** (called the **premium**) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, <http://www.thelocalchoice.virginia.gov/planinfo/employeeplans.html>. For general definitions of common terms, such as **allowed amount, balance billing, coinsurance, copayment, deductible, provider**, or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call 1-888-642-4414 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <b>deductible</b> ?	<b>\$1,000</b> /person or <b>\$2,000</b> /family for in-network providers. <b>\$2,000</b> /person or <b>\$4,000</b> /family for out-of-network providers.	Generally you must pay all of the costs from <b>providers</b> up to the <b>deductible</b> amount before this <b>plan</b> begins to pay. If you have other family members on the <b>plan</b> , each family member must meet their own individual <b>deductible</b> until the total amount of <b>deductible</b> expenses paid by all family members meets the overall family <b>deductible</b> .
Are there services covered before you meet your <b>deductible</b> ?	Yes. Preventive services, in-network care including office visits, and routine vision.	This <b>plan</b> covers some items and services even if you haven't yet met the <b>deductible</b> amount. But a <b>copayment</b> or <b>coinsurance</b> may apply. For example, this plan covers certain <b>preventive services</b> without <b>cost-sharing</b> and before you meet your <b>deductible</b> . See a list of covered <b>preventive services</b> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits">https://www.healthcare.gov/coverage/preventive-care-benefits</a> .
Are there other <b>deductibles</b> for specific services?	No.	You don't have to meet <b>deductibles</b> for specific services.
What is the <b>out-of-pocket limit</b> for this <b>plan</b> ?	<b>\$5,000</b> /person or <b>\$10,000</b> /family for in-network provider. <b>\$9,000</b> /person or <b>\$18,000</b> /family for out-of-network provider.	The <b>out-of-pocket limit</b> is the most you could pay in a year for covered services. If you have other family members in this <b>plan</b> , they have to meet their own <b>out-of-pocket limits</b> until the overall family <b>out-of-pocket limit</b> has been met.
What is not included in the <b>out-of-pocket limit</b> ?	Dental, routine vision, <b>premiums, balance-billed</b> charges, and health care this <b>plan</b> doesn't cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
Will you pay less if you use a <b>network provider</b> ?	Yes. See <a href="http://www.anthem.com">www.anthem.com</a> or call 1-800-552-2682 for a list of <b>network providers</b> .	This <b>plan</b> uses a <b>provider network</b> . You will pay less if you use a <b>provider</b> in the <b>plan's network</b> . You will pay the most if you use an <b>out-of-network provider</b> , and you might receive a bill from a <b>provider</b> for the difference between the <b>provider's</b> charge and what

\* For more information about limitations and exceptions, see the **plan** or policy document at [www.thelocalchoice.virginia.gov](http://www.thelocalchoice.virginia.gov).

Important Questions	Answers	Why This Matters:
		your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the specialist you choose without a <a href="#">referral</a> .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's office</a> or clinic	Primary care visit to treat an injury or illness	\$25/visit	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Balance billing</a> may occur for out-of-network services.
	<a href="#">Specialist</a> visit	\$40/visit	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Balance billing</a> may occur for out-of-network services.
	<a href="#">Preventive care/screening</a> /immunization	No charge	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Balance billing</a> may occur for out-of-network services.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Balance billing</a> may occur for out-of-network services.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Balance billing</a> may occur for out-of-network services.
If you need drugs to treat your illness or condition  More information about <a href="#">prescription</a>	Tier 1 - Typically Generic drugs	\$10/ <a href="#">copay</a> (retail); \$20/ <a href="#">copay</a> (home delivery)	\$10/ <a href="#">copay</a> (retail); \$20/ <a href="#">copay</a> (home delivery)	Retail up to 34 day supply; home delivery up to 90 day supply. Mandatory generic program. If you or your doctor requests a brand named drug when a generic is available, you pay the brand <a href="#">copay</a> plus the difference between the allowable
	Tier 2 - Typically Preferred / Brand drugs	\$30/ <a href="#">copay</a> (retail); \$60/ <a href="#">copay</a> (home delivery)	\$30/ <a href="#">copay</a> (retail); \$60/ <a href="#">copay</a> (home delivery)	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.thelocalchoice.virginia.gov](http://www.thelocalchoice.virginia.gov).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<a href="#">drug coverage</a> is available at <a href="http://anthem.com/tlc">anthem.com/tlc</a>	Tier 3 - Typically Non-Preferred / <a href="#">Specialty drugs</a>	\$45/ <a href="#">copay</a> (retail); \$90/ <a href="#">copay</a> (home delivery)	\$45/ <a href="#">copay</a> (retail); \$90/ <a href="#">copay</a> (home delivery)	charge for the generic and the brand named drug. <a href="#">Balance billing</a> may occur for out-of-network services.
	Tier 4 - Typically <a href="#">Specialty drugs</a>	\$55/ <a href="#">copay</a> (retail); \$110/ <a href="#">copay</a> (home delivery)	\$55/ <a href="#">copay</a> (retail); \$110/ <a href="#">copay</a> (home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Balance billing</a> may occur for out-of-network services.
	Physician/surgeon fees	\$25 PCP; \$40 Specialist/visit	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Balance billing</a> may occur for out-of-network services.
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Covered as In-Network	Copay waived if admitted. <a href="#">Balance billing</a> may occur for out-of-network services.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Covered as In-Network	<a href="#">Balance billing</a> may occur for out-of-network services.
	<a href="#">Urgent care</a>	\$25 PCP; \$40 Specialist/visit	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Balance billing</a> may occur for out-of-network services.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Balance billing</a> may occur for out-of-network services.
	Physician/surgeon fee	No charge	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Balance billing</a> may occur for out-of-network services.
If you need mental health, behavioral health, or substance abuse needs	Outpatient services	Office Visit \$25/visit Other Outpatient 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Balance billing</a> may occur for out-of-network services.
	Inpatient services	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Balance billing</a> may occur for out-of-network services. Employee Assistance Program (EAP) covered at

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				no charge with up to 4 visits per incident per <a href="#">plan</a> year.
If you are pregnant	Office visits	\$25 PCP; \$40 Specialist/visit	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) <a href="#">Balance billing</a> may occur for out-of-network services.
	Childbirth/delivery professional services	No charge	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	90 visits/benefit period. <a href="#">Balance billing</a> may occur for out-of-network services.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Balance billing</a> may occur for out-of-network services.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Balance billing</a> may occur for out-of-network services.
	<a href="#">Skilled nursing care</a>	No charge	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	180 day/benefit period. <a href="#">Balance billing</a> may occur for out-of-network services.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Balance billing</a> may occur for out-of-network services.
	<a href="#">Hospice service</a>	No charge	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Balance billing</a> may occur for out-of-network services.
If your child needs dental or eye care	Eye exam	\$40 <a href="#">copay</a>	Balance after \$50	Limit one exam per plan year under the age of 19.
	Glasses	\$20 <a href="#">copay</a> for lenses; balance over \$100 for frames	Balance after \$50 for single lenses; balance over \$80 for frames	-----none-----
	Dental check-up	No charge	Covered as in-network	<a href="#">Balance billing</a> may occur for out-of-network services.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.thelocalchoice.virginia.gov](http://www.thelocalchoice.virginia.gov).

## Excluded Services & Other Covered Services:

### Services Your [Plan](#) Does NOT Cover (This isn't a complete list. Check your policy or plan document for other [excluded services](#).)

- Acupuncture
- Infertility treatment
- Weight loss programs
- Cosmetic surgery
- Long-term care
- Hearing aids
- Routine foot care unless you have been diagnosed with diabetes

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

- Bariatric surgery
- Most coverage provided outside the United States. See [www.bcbs.com](http://www.bcbs.com).
- Chiropractic care
- Private-duty nursing
- Routine eye care
- Dental care (adult) - diagnostic and preventive only

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

### Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to [appeal](#) or file a [grievance](#). For questions about your rights, this notice, or assistance, you can contact: Director, Department of Human Resource Management, 101 North 14<sup>th</sup> Street – 12<sup>th</sup> Floor, Richmond, Virginia 23219-3657. Mark envelope Confidential-Appeal Enclosed. Telephone: 1-888-642-4414.

### Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

—————To see examples of how this plan might cover costs for a sample medical situation, see the next section.—————

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,000
■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

#### This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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#### In this example, Peg would pay:

<a href="#">Cost Sharing</a>	
Deductibles	\$1,000
Copayments	\$90
Coinsurance	\$2,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,150</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,000
■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

#### This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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#### In this example, Joe would pay:

<a href="#">Cost Sharing</a>	
Deductibles	\$1,000
Copayments	\$980
Coinsurance	\$370
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$2,410</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,000
■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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#### In this example, Mia would pay:

<a href="#">Cost Sharing</a>	
Deductibles	\$1,000
Copayments	\$120
Coinsurance	\$320
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,440</b>

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-888-642-4414.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

# Language Access Services:

(TTY/TDD: 711)

**Albanian (Shqip):** Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi 1-800-552-2682

**Amharic (አማርኛ):-** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር 1-800-552-2682 ይደውሉ።

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على 1-800-552-2682

**Armenian (հայերեն).** Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ 1-800-552-2682 :

**Bassa (Bàsɔ̀ Wùdù):** M̄ dyi dyi-diè-dɛ̀ bɛ̀ bédé b́á céè-dɛ̀ nìà ke dyí ní, ɔ̀ m̀ò nì dyí-bɛ̀dɛ̀in-dɛ̀ bɛ̀ m̄ kɛ̀ gbo-kpá-kpá kè b̄́ kp̄́ dɛ̀ m̄ bídí-wùdùùn b́ó pídyi. B́é m̄ kɛ̀ wuɖu-zìin-nyò d̀ò gbo wùdù kɛ̀, d́á 1-800-552-2682.

**Bengali (বাংলা):** যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্য সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য 1-800-552-2682 -তে কল করুন।

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန် 1-800-552-2682 သို့ ခေါ်ဆိုပါ။

**Chinese (中文) :** 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電 1-800-552-2682。

**Dinka (Dinka):** Na n̄ɔŋ thiëc nē ke de yā thorē, ke yin n̄ɔŋ loŋ bē yi kuony ku w̄er alēu bē ḡɛɛr yic yin ne thoŋ du ke cin w̄eu tāäuē ke piny. Te k̄or yin ba jam w̄enē ran ye thok geryic, ke yin c̄ol 1-800-552-2682.

**Dutch (Nederlands):** Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u 1-800-552-2682.

**Farsi (فارسي):** در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره 1-800-552-2682 تماس بگیرید.





## Language Access Services:

**Khmer (ខ្មែរ):** បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។  
ដើម្បីជ្រកជាមួយអ្នកបកប្រែ សូមហៅ 1-800-552-2682 ។

**Kirundi (Kirundi):** Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura 1-800-552-2682.

**Korean (한국어):** 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 1-800-552-2682 로 문의하십시오.

**Lao (ພາສາລາວ):** ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.  
ເພື່ອໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ໃຫ້ໃບສາ, ໃຫ້ໃບສາ 1-800-552-2682.

**Navajo (Diné):** Dii naaltsoos biká'ígíí lahgo bina'idiłkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehjı́ bee nił hodoonih t'áadoo bą́ąh ilínígóó.  
Ata' halne'ígíí la' bich'i' hadeesdzih nínízingo koꞓ' hodíilnih 1-800-552-2682.

**Nepali (नेपाली):** यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ।  
दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् 1-800-552-2682

**Oromo (Oromifaa):** Sanadi kanaa wajiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, 1-800-552-2682 bilbilla.

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**Punjabi (ਪੰਜਾਬੀ):** ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, 1-800-552-2682 ਤੇ ਕਾਲ ਕਰੋ।

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## Language Access Services:

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