

Schedule of Benefits (Who Pays What)
Anthem Blue Cross and Blue Shield

Name of Carrier
BlueClassic for Group
 Name of Plan
30-60-2000/5000-70%
15/50/70/30%

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Preferred Provider plan
2. OUT-OF-NETWORK CARE COVERED?¹	Yes, but the patient pays more for Out-of-Network care
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available throughout Colorado

PART B: SUMMARY OF BENEFITS

Important Note: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require Precertification, prior authorization, a referral from your Primary Care Provider, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage. Coinsurance and copayment options reflect the amount the covered person will pay.

	IN-NETWORK	OUT-OF-NETWORK
4. DEDUCTIBLE TYPE²	Calendar Year	Calendar Year
4a. ANNUAL DEDUCTIBLE^{2a} a) Individual^{2b} b) Family^{2c}	\$2,000, excludes Copayments \$6,000, excludes Copayments One Member may not contribute any more than the individual Deductible towards the family Deductible. Some Covered Services have a maximum benefit of days, visits or dollar amounts allowed. When the Deductible is applied to a Covered Service which has a maximum benefit of days or visits, those maximum benefits will be reduced by the amount applied toward the Deductible, whether or not the Covered Service is paid.	\$6,000, excludes Copayments \$18,000, excludes Copayments One Member may not contribute any more than the individual Deductible towards the family Deductible. Some Covered Services have a maximum benefit of days, visits or dollar amounts allowed. When the Deductible is applied to a Covered Service which has a maximum benefit of days or visits, those maximum benefits will be reduced by the amount applied toward the Deductible, whether or not the Covered Service is paid.

Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. HMO products are underwritten by HMO Colorado, Inc. Independent licensees of the Blue Cross and Blue Shield Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente.

If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling member services at the number on the back of your Health Benefit ID Card.

	IN-NETWORK	OUT-OF-NETWORK
<p>5. OUT-OF-POCKET ANNUAL MAXIMUM³</p> <p>a) Individual</p> <p>b) Family</p> <p>c) Is deductible included in the out-of-pocket maximum?</p>	<p>\$5,000 Copayments, Deductible and Coinsurance are included in the Out-of-Pocket Annual Maximum.</p> <p>\$10,000 Copayments, Deductible and Coinsurance are included in the Out-of-Pocket Annual Maximum.</p> <p>One Member may not contribute any more than the individual Out-of-Pocket Annual Maximum towards the family Out-of-Pocket Annual Maximum.</p> <p>Yes</p> <p>Some Covered Services have a maximum benefit of days, visits or dollar amounts allowed. These maximums apply even if the applicable Out-of-Pocket Annual Maximum is satisfied.</p>	<p>\$15,000 Copayments, Deductible and Coinsurance are included in the Out-of-Pocket Annual Maximum.</p> <p>\$30,000 Copayments, Deductible and Coinsurance are included in the Out-of-Pocket Annual Maximum.</p> <p>One Member may not contribute any more than the individual Out-of-Pocket Annual Maximum towards the family Out-of-Pocket Annual Maximum.</p> <p>Yes</p> <p>Some Covered Services have a maximum benefit of days, visits or dollar amounts allowed. These maximums apply even if the applicable Out-of-Pocket Annual Maximum is satisfied. The difference between Billed Charges and the Maximum Allowed Amount for non-participating Providers does not count toward the Out-of-Pocket Annual Maximum. Even once the Out-of-Pocket Annual Maximum is satisfied, you will still be responsible for paying the difference between the Maximum Allowed Amount and the non-participating Providers Billed Charges (sometimes called "balance billing").</p> <p>The amounts you pay for Out-of-Network Covered Services are in addition to your balance billing costs.</p>
<p>6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE</p>	<p>No lifetime maximum for most Covered Services.</p>	<p>No lifetime maximum for most Covered Services.</p>
<p>7A. COVERED PROVIDERS</p>	<p>Anthem Blue Cross and Blue Shield PPO Provider network. See Provider directory for complete list of current Providers.</p>	<p>All Providers licensed or certified to provide Covered Services.</p>
<p>7B. With respect to network plans, are all the providers listed in 7A accessible to me through my Primary Care Provider?</p>	<p>Yes</p>	<p>Yes</p>

	IN-NETWORK	OUT-OF-NETWORK
8. MEDICAL OFFICE VISITS⁴ a) Primary Care Providers b) Specialists	\$30 Copayment per office visit. You pay 30% after Deductible for all other services (e.g., laboratory and x-ray services) \$60 Copayment per office visit. You pay 30% after Deductible for all other services (e.g., laboratory and x-ray services)	You pay 50% after Deductible You pay 50% after Deductible
9. PREVENTIVE CARE a) Children's services b) Adult's services	No Copayment (100% covered) No Copayment (100% covered)	You pay 50% after Deductible You pay 50% after Deductible
10. MATERNITY a) Prenatal care b) Delivery & inpatient well baby care⁵	\$60 Copayment for services from a Primary Care Provider or \$60 Copayment for services from a Specialist, for first prenatal care office visit/delivery from the Doctor. You pay 30% after Deductible for all other services (e.g., laboratory and x-ray services). You pay 30% after Deductible	You pay 50% after Deductible for prenatal care office visits/delivery from the Doctor You pay 50% after Deductible
11. PRESCRIPTION DRUGS Level of coverage and restrictions on prescriptions⁶	<p>Inpatient Care - Included with the inpatient Hospital benefit (see line 12).</p> <p>Outpatient Care Retail Pharmacy - Tier 1 \$15 Copayment, tier 2 \$50 Copayment, tier 3 \$70 Copayment, tier 4 30% Copayment, per prescription up to a 30-day supply. For tier 4 Retail Pharmacy Drugs, the maximum Copayment per prescription is \$350 per 30-day supply.</p> <p>Tier 1, tier 2 and tier 3 non-specialty Maintenance Medications may be filled up to a 90-day supply at a Maintenance Pharmacy. You are required to pay a Retail Pharmacy Copayment for each 30-day supply.</p> <p>Outpatient Care Specialty Pharmacy - Tier 1 \$15 Copayment, tier 2 \$50 Copayment, tier 3 \$70 Copayment, tier 4 30% Copayment, per prescription up to a 30-day supply. For tier 4 Specialty Pharmacy Drugs the maximum Copayment per prescription is \$350 per 30-day supply. Certain Specialty Drugs are only available from the Specialty</p>	<p>Inpatient Care - Included with the inpatient Hospital benefit (see line 12).</p> <p>Outpatient Care Retail Pharmacy Drugs - Not covered</p> <p>Outpatient Care Specialty Pharmacy Drugs - Not covered</p>

	IN-NETWORK	OUT-OF-NETWORK
	<p>Pharmacy and you will not be able to get them at a Retail Pharmacy or through the Home Delivery (Mail Order) Pharmacy. When you get Specialty Drugs from the Specialty Pharmacy, you will have to pay the same Copayment you pay for a 30-day supply at a Retail Pharmacy.</p> <p>Outpatient Care Home Delivery Pharmacy - Tier 1 \$37.50 Copayment, tier 2 \$150 Copayment, tier 3 \$210 Copayment, per prescription up to a 90-day supply. Specialty pharmacy drugs are not available through the Home Delivery Pharmacy.</p>	<p>Outpatient Care Home Delivery Pharmacy Drugs - Not covered</p>
12. INPATIENT HOSPITAL	You pay 30% after Deductible	You pay 50% after Deductible
13. OUTPATIENT / AMBULATORY SURGERY AT A FACILITY	You pay 30% after Deductible	You pay 50% after Deductible
14. DIAGNOSTICS		
a) Laboratory & x-ray	You pay 30% after Deductible	You pay 50% after Deductible.
b) MRI, nuclear medicine, and other high-tech services	You pay 30% after Deductible	You pay 50% after Deductible.
15. EMERGENCY CARE¹	You pay 30% after Deductible	Out-of-Network care is paid as In-Network
16. AMBULANCE	You pay 30% after Deductible	Out-of-Network care is paid as In-Network; non-emergency ambulance services will be limited to a maximum benefit of \$50,000 per occurrence.
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	\$60 Copayment per visit. You pay 30% after Deductible for all other services including laboratory and x-ray services.	You pay 50% after Deductible
18. MENTAL HEALTH CARE		
a) Inpatient care	You pay 30% after Deductible	You pay 50% after Deductible
b) Outpatient care	<p>For outpatient facility services, you pay 30% after Deductible; for outpatient office visits and professional services (including online visits), you pay \$30 Copayment per visit.</p> <p>Mental health care includes without limitation, biologically based mental illness, care that has a psychiatric diagnosis or that require specific psychotherapeutic treatment, regardless of the underlying condition.</p>	<p>You pay 50% after Deductible</p> <p>Mental health care includes without limitation, biologically based mental illness, care that has a psychiatric diagnosis or that require specific psychotherapeutic treatment, regardless of the underlying condition.</p>

	IN-NETWORK	OUT-OF-NETWORK
19. ALCOHOL & SUBSTANCE ABUSE	<p>Inpatient Care - You pay 30% after Deductible</p> <p>Outpatient Care - For outpatient facility services, you pay 30% after Deductible; for outpatient office visits and professional services (including online visits), you pay \$30 Copayment per visit.</p>	<p>Inpatient Care - You pay 50% after Deductible</p> <p>Outpatient Care - You pay 50% after Deductible</p>
20. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	<p>Inpatient Care - Included with the inpatient Hospital benefit (see line 12). Up to 30 inpatient rehab days per calendar year In and Out-of-Network combined.</p> <p>Outpatient Care - You pay 30% after Deductible. Up to 20 visits each for physical, occupational and speech therapy per calendar year In and Out-of-Network combined. From birth until the Member's sixth birthday, benefits are provided as required by applicable law.</p>	<p>Inpatient Care - Included with the inpatient Hospital benefit (see line 12). Up to 30 inpatient rehab days per calendar year In and Out-of-Network combined.</p> <p>Outpatient Care - You pay 50% after Deductible. Up to 20 visits each for physical, occupational and speech therapy per calendar year In and Out-of-Network combined. From birth until the Member's sixth birthday benefits are provided as required by applicable law.</p>
21. DURABLE MEDICAL EQUIPMENT	You pay 30% after Deductible. One wig after cancer treatment up to a maximum benefit of \$500 per Member.	Not covered
22. OXYGEN	You pay 30% after Deductible	Not covered
23. ORGAN TRANSPLANTS	<p>Inpatient Care - You pay 30% after Deductible</p> <p>Outpatient Care - \$30 Copayment per office visit for services from a Primary Care Provider or \$60 Copayment per office visit for services from a Specialist. You pay 30% after Deductible for all other services (e.g., laboratory and x-ray services).</p> <p>Transportation and lodging services are limited to a maximum benefit of \$10,000 per Transplant Benefit Period; unrelated donor searches are limited to a maximum benefit of \$30,000 per Transplant Benefit Period.</p>	<p>Inpatient Care - Not covered</p> <p>Outpatient Care - Not covered</p>
24. HOME HEALTH CARE	You pay 30% after Deductible. Up to 100 visits per calendar year.	Not covered
25. HOSPICE CARE	<p>Inpatient Care - You pay no Deductible or Coinsurance</p> <p>Outpatient Care - You pay no Deductible or Coinsurance</p>	<p>Inpatient Care - You pay 50% after Deductible</p> <p>Outpatient Care - You pay 50% after Deductible</p>

	IN-NETWORK	OUT-OF-NETWORK
26. SKILLED NURSING FACILITY CARE	You pay 30% after Deductible. Up to 100 days per calendar year In and Out-of-Network combined.	You pay 50% after Deductible. Up to 100 days per calendar year In and Out-of-Network combined.
27. DENTAL CARE	Not covered	Not covered
28. VISION CARE	Not covered	Not covered
29. CHIROPRACTIC THERAPY	\$30 Copayment per office visit. You pay 30% after Deductible for all other services (e.g., laboratory and x-ray services). Up to 20 visits per calendar year, regardless of which type of Provider renders the therapy.	Not covered
30. SIGNIFICANT ADDITIONAL COVERED SERVICES	<p>Retail Health Clinic \$30 Copayment per office visit. You pay 30% after Deductible for all other services (e.g., laboratory and x-ray services).</p> <p>Online Visits \$30 Copayment per visit.</p> <p>For Mental Health or Substance Abuse see lines 18 and 19 for payment information.</p> <p>Other Covered Services</p> <ul style="list-style-type: none"> • Massage Therapy - \$30 Copayment per office visit. Up to 20 visits per calendar year combined for massage and acupuncture therapy, regardless of which type of Provider renders the therapy. • Acupuncture/Nerve Pathway Therapy - \$30 Copayment per office visit. You pay 30% after Deductible for all other services (e.g., laboratory and x-ray services). Up to 20 visits per calendar year combined for massage and acupuncture therapy, regardless of which type of Provider renders the therapy. • Nutritional Counseling (other than for eating disorders and Diabetes Management) - \$30 Copayment per visit for Specialist. Up to 4 visits per calendar year. • Nutritional Counseling for eating disorders - Covered under Mental Health Care, please see row 19. • Nutritional Counseling for Diabetes Management - Benefit level determined by place of service. <p>Hearing Aids Benefit level determined by place of</p>	<p>Retail Health Clinic Not covered</p> <p>Online Visits Not covered</p> <p>Other Covered Services</p> <ul style="list-style-type: none"> • Massage Therapy – Not covered • Acupuncture/Nerve Pathway Therapy – Not covered • Nutritional Counseling (other than for eating disorders and Diabetes Management) - Not covered • Nutritional Counseling for eating disorders - Covered under Mental Health Care, please see row 19. • Nutritional Counseling for Diabetes Management - Benefit level determined by place of service. <p>Hearing Aids Benefit level determined by place of</p>

	IN-NETWORK	OUT-OF-NETWORK
	<p>service. Hearing aids are covered up to age 18. Initial and replacement hearing aids will be supplied once every 5 years.</p> <p>New hearing aids will be a covered service when alterations to your existing hearing aids cannot adequately meet your needs or be repaired.</p> <p>General Information For outpatient Covered Service not elsewhere listed, you pay Coinsurance after Deductible. For example, this includes chemotherapy and outpatient non-surgical facility services. However, some covered services may require a Copayment prior to and in addition to the Coinsurance.</p>	<p>service. Hearing aids are covered up to age 18. Initial and replacement hearing aids will be supplied once every 5 years.</p> <p>New hearing aids will be a covered service when alterations to your existing hearing aids cannot adequately meet your needs or be repaired.</p> <p>General Information For outpatient Covered Service not elsewhere listed, you pay Coinsurance after Deductible. For example, this includes chemotherapy and outpatient non-surgical facility services. However, some covered services may require a Copayment prior to and in addition to the Coinsurance.</p>

PART C: LIMITATIONS AND EXCLUSIONS

31. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED.	Not applicable; plan does not impose limitation periods for pre-existing conditions.
32. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No
33. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	Not applicable; plan does not exclude coverage for pre-existing conditions.
34. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier, agent, or plan sponsor (e.g., employer). Review the list to see if a service or treatment you may need is excluded from the policy.

PART D: USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
35. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No	No
36. Is Precertification required for surgical procedures and hospital care (except in an emergency)?	Yes, the Doctor who schedules the procedure or Hospital care is responsible for obtaining the Precertification.	Yes, you are responsible for obtaining Precertification.
37. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	<p>Yes, you will be responsible for paying the difference between the Maximum Allowed Amount and the non-participating Provider's Billed Charges (sometimes called "balance billing").</p> <p>The amounts you pay for Out-of-Network Covered Services are in addition to your balance billing costs.</p>
38. What is the main member service number?	877-811-3106	
39. Whom do I write/call if I have a complaint or want to file a grievance?	Anthem Blue Cross and Blue Shield Complaints and Appeals 700 Broadway, Denver, CO 80273 877-811-3106	

40. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850, Denver, CO 80202
41. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.	Policy form #'s COLGPPONGF Large Group
42. Does the plan have a binding arbitration clause?	Yes

¹ “Network” refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e., go in-network) than if you don’t (i.e., go out-of-network).

² “Deductible Type” indicates whether the deductible period is “Calendar Year” (January 1 through December 31) or “Benefit Year” (i.e., based on a benefit year beginning on the policy’s anniversary date) or if the deductible is based on other requirements such as a “Per Accident or Injury” or Per Confinement”.

^{2a} “Deductible” means the amount you will have to pay for allowable covered expenses under a health plan during a specified time period (e.g., a calendar year or benefit year) before the carrier will cover those expenses. The specific expenses that are subject to deductible may vary by policy. Expenses that are subject to deductible should be noted in boxes 8 through 30.

^{2b} “Individual” means the deductible amount you and each individual covered by a non-HSA qualified policy will have to pay for the allowable covered expenses before the carrier will cover those expenses. “Single” means the deductible amount you will have to pay for allowable covered expenses under an HSA-qualified health plan when you are the only individual covered by the plan.

^{2c} “Family” is the maximum deductible amount that is required to be met for all family members covered by a non-HSA qualified policy and it may be an aggregated amount (e.g., “\$3,000 per family”) or specified as the number of individual deductibles that must be met (e.g., “3 deductibles per family”). “Non-single” is the deductible amount that must be met by one or more family members covered by an HSA-qualified plan before any covered expenses are paid.

³ “Out-of-pocket maximum” means the maximum amount you will have to pay for allowable covered expenses under a health plan.

⁴ Medical office visits include physician, mid-level practitioner, and specialist visits.

⁵ Well baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. The hospital copayment applies to mother and well-baby together: there are not separate copayments.

⁶ Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.

⁷ “Emergency care” means all services delivered in an emergency care facility which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life- or limb threatening emergency existed.

Cancer Screenings

At Anthem Blue Cross and Blue Shield and Our subsidiary company, HMO Colorado, Inc., We believe cancer screenings provide important preventive care that supports Our mission: to improve the lives of the people We serve and the health of Our communities. We cover cancer screenings as described below.

Pap Tests

All plans provide coverage under the preventive care benefits for a routine annual Pap test and the related office visit. Payment for the routine Pap test is based on the plan's provisions for preventive care. Payment for the related office visit is based on the plan's preventive care provisions.

Mammogram Screenings

All plans provide coverage under the preventive care benefits for routine screening or diagnostic mammogram regardless of age. Payment for the mammogram screening benefit is based on the plan's provisions for preventive care.

Prostate Cancer Screenings

All plans provide coverage under the preventive care benefits for routine prostate cancer screening for men. Payment for the prostate cancer screening is based on the plan's provisions for preventive care.

Colorectal Cancer Screenings

Several types of colorectal cancer screening methods exist. All plans provide coverage for routine colorectal cancer screenings, such as fecal occult blood tests, barium enema, sigmoidoscopies and colonoscopies. Depending on the type of colorectal cancer screening received, payment for the benefit is based on where the services are rendered and if rendered as a screening or medical procedure. Colorectal cancer screenings are covered under preventive care as long as the services provided are for a preventive screening. Payment for preventive colorectal cancer screenings is based on the plan's provisions for preventive care.

**NOTICE OF
PROTECTION PROVIDED BY
LIFE AND HEALTH INSURANCE PROTECTION ASSOCIATION**

This notice provides a **brief summary** of the Life and Health Insurance Protection Association (“the Association”) and the protection it provides for policyholders. This safety net was created under Colorado law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Colorado law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
 - \$300,000 in death benefits
 - \$100,000 in cash surrender or withdrawal values
- Health Insurance
 - \$500,000 in hospital, medical and surgical insurance benefits
 - \$300,000 in disability insurance benefits
 - \$300,000 in long-term care insurance benefits
 - \$100,000 in other types of health insurance benefits
- Annuities
 - \$250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$300,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Colorado law.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association’s website www.colifega.org, email jwrhodes@colifega.org or contact:

<i>Colorado Life and Health Insurance Protection Association</i> 201 Robert S. Kerr Ave. Suite 600 Oklahoma City, OK 73102 1-800-337-7796	<i>Colorado Division of Insurance</i> 1560 Broadway, Suite 850 Denver, CO 80202 (303) 894-7499
--	---

Insurance companies and agents are not allowed by Colorado law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Colorado law, then Colorado law will control.

Get help in your language

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

You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (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 Member Services telephone number on the back of your ID card.

Spanish

Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Albanian

Keni të drejtën të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për ndihmë, telefononi numrin e shërbimeve për anëtarët, të shënuar në kartën tuaj ID. (TTY/TDD: 711)

Amharic

ይህንን መረጃ እና እገዛ በቋንቋዎ በነጻ እገዛ የማግኘት መብት አልዎት። ለእገዛ በመታወቂያዎ ላይ ያለውን የአባል አገልግሎቶች ቁጥር ይደውሉ።(TTY/TDD: 711)

Arabic

يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة (TTY/TDD: 711).

Armenian

Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Bassa

Ìm bédé dyí-bèdèin-dèò b'é m k'é b'í n'ia k'e k'e gbo-kpá- kpá dyé q'é m bídí-wùdùün bó pídyi. Ìá méfà jè gbo-gmò Kpòè nòbà n'ia nì Dyí-dyoin-b'èè k'è b'é m k'é gbo-kpá-kpá dyé. (TTY/TDD: 711)

Bengali

আপনার বিনামূল্যে এই তথ্য পাওয়ার ও আপনার ভাষায় সাহায্য করার অধিকার আছে। সাহায্যের জন্য আপনার আইডি কার্ডে থাকা সদস্য পরিষেবা নম্বরে কল করুন।(TTY/TDD: 711)

Burmese

ဤအချက်အလက်များနှင့် အကူအညီကို သင့်ဘာသာစကားဖြင့် အခမဲ့ ရပိုင်ခွင့် သင့်တွင်ရှိပါသည်။ အကူအညီ ရယူရန် သင့် ID ကဒ်ပေါ်ရှိ အဖွဲ့ဝင်အတွက် ဝန်ဆောင်မှုများ ဌာန၏ နံပါတ်သို့ ခေါ်ဆိုပါ။

(TTY/TDD: 711)

Chinese

您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Dinka

Yin non̄ yic ba ye lèk nè yök ku bë yi kuony nè thön̄ yin jām ke cin wëu töu kē piiny. Col rān tön̄ dē koc kē luoi nè nām̄ba dēn tö nè I.D kat du yic. (TTY/TDD: 711)

Dutch

U hebt het recht om deze informatie en hulp gratis in uw taal te krijgen. Bel het ledendienstnummer op uw ID-kaart voor ondersteuning. (TTY/TDD: 711)

Farsi

شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناساییتان درج شده است، تماس بگیرید. (TTY/TDD: 711)

French

Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

German

Sie haben das Recht, diese Informationen und Unterstützung kostenlos in Ihrer Sprache zu erhalten. Rufen Sie die auf Ihrer ID-Karte angegebene Servicenummer für Mitglieder an, um Hilfe anzufordern. (TTY/TDD: 711)

Greek

Έχετε το δικαίωμα να λάβετε αυτές τις πληροφορίες και αυτήν τη βοήθεια στη γλώσσα σας δωρεάν. Καλέστε τον αριθμό του Τμήματος Υπηρεσιών Μέλους (Member Services) που αναγράφεται στην ταυτότητά σας (ID card) για βοήθεια. (TTY/TDD: 711)

Gujarati

તમે તમારી ભાષામાં મફતમાં આ માહિતી અને મદદ મેળવવાનો અધિકાર ધરાવો છો. મદદ માટે તમારા આઈડી કાર્ડ પરના મેમ્બર સર્વિસ નંબર પર કોલ કરો. (TTY/TDD: 711)

Haitian

Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Hindi

आपके पास यह जानकारी और मदद अपनी भाषा में मुफ्त में प्राप्त करने का अधिकार है। मदद के लिए अपने ID कार्ड पर सदस्य सेवाएँ नंबर पर कॉल करें। (TTY/TDD: 711)

Hmong

Koj muaj cai tau txais qhov lus qhia no thiab kev pab hais ua koj hom lus yam tsis xam tus nqi. Hu rau tus nab npawb xov tooj lis Cov Kev Pab Cuam Rau Tswv Cuab nyob rau ntawm koj daim ID txhawm rau thov kev pab. (TTY/TDD: 711)

Igbo

Ị nwere ikike ịnweta ozi a yana enyemaka n'asụsụ gị n'efu. Kpọọ nomba Ọrụ Onye Otu dị na kaadi NJ gị maka enyemaka. (TTY/TDD: 711)

Ilokano

Addanka ti karbengan a maala iti daytoy nga impormasyon ken tulong para ti lengguahem nga awanan ti bayadna. Awagan ti numero ti Serbisyo para ti Kameng a masarakan ayan ti ID kard mo para ti tulong. (TTY/TDD: 711)

Indonesian

Anda berhak untuk mendapatkan informasi ini dan bantuan dalam bahasa Anda secara gratis. Hubungi nomor Layanan Anggota pada kartu ID Anda untuk mendapatkan bantuan. (TTY/TDD: 711)

Italian

Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Japanese

この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Khmer

អ្នកមានសិទ្ធិក្នុងការទទួលបានព័ត៌មាននេះ និងទទួលបានជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ សូមហៅទូរស័ព្ទទៅលេខសេវាសមាជិកដែលមានលើប័ណ្ណ ID របស់អ្នកដើម្បីទទួលបានជំនួយ។ (TTY/TDD: 711)

Kirundi

Ufise uburenganzira bwo gufashwa mu rurimi rwawe ku buntu. Akura umunywanyi abikora Ikaratakarangamuntu yawe kugira ufashwe. (TTY/TDD: 711)

Korean

귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Lao

ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທຫາເບີໂທຂອງຝ່າຍບໍລິການສະມາຊິກທີ່ໃຫ້ໄວ້ໃນບັດປະຈຳຕົວຂອງທ່ານເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ. (TTY/TDD: 711)

Navajo

Bee n1 ahoot'i t'11 ni nizaad k'ehj7 n7k1 a'doowo[t'11 j77k'e. Naaltsoos bee atah n7l7n7g77 bee n44ho'd0lzingo nanitin7g77 b44sh bee hane'7 bik11' 1aj8' hod77lnih. Naaltsoos bee atah n7l7n7g77 bee n44ho'd0lzingo nanitin7g77 b44sh bee hane'7 bik11' 1aj8' hod77lnih. (TTY/TDD: 711)

Nepali

तपाईंले यो जानकारी तथा सहयोग आफ्नो भाषामा निःशुल्क प्राप्त गर्ने तपाईंको अधिकार हो। सहायताको लागि तपाईंको ID कार्डमा दिइएको सदस्य सेवा नम्बरमा कल गर्नुहोस्।(TTY/TDD: 711)

Oromo

Odeeffanoo kana fi gargaarsa afaan keetiin kaffaltii malee argachuuf mirga qabda. Gargaarsa argachuuf lakkoofsa bilbilaa tajaajila miseensaa (Member Services) waraqaa enyummaa kee irratti argamu irratti bilbili. (TTY/TDD: 711)

Pennsylvania Dutch

Du hoscht die Recht selle Information un Hilfe in dei Schprooch mitaus Koscht griege. Ruf die Member Services Nummer uff dei ID Kaarte fer Hilfe aa. (TTY/TDD: 711)

Polish

Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Portuguese-Europe

Tem o direito de receber gratuitamente estas informações e ajuda no seu idioma. Ligue para o número dos Serviços para Membros indicado no seu cartão de identificação para obter ajuda. (TTY/TDD: 711)

Punjabi

ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Romanian

Aveți dreptul să obțineți aceste informații și asistență în limba dvs. în mod gratuit. Pentru asistență, apălați numărul departamentului de servicii destinate membrilor de pe cardul dvs. de identificare. (TTY/TDD: 711)

Russian

Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Samoan

E iai lou 'aia faaletulafono e maua nei faamatalaga ma se fesoasoani i lou lava gagana e aunoa ma se totogi. Vili le numera mo Sauniuniga mo lou Vaega o loo maua i lou pepa faailoa ID mo se fesoasoani. (TTY/TDD: 711)

Serbian

Imate pravo da dobijete sve informacije i pomoć na vašem jeziku, i to potpuno besplatno. Pozovite broj Centra za podršku članovima koji se nalazi na vašoj identifikacionoj kartici. (TTY/TDD: 711)

Tagalog

May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Thai

ท่านมีสิทธิขอรับบริการสอบถามข้อมูลและความช่วยเหลือในภาษาของท่านฟรี
โทรไปที่หมายเลขฝ่ายบริการสมาชิกบนบัตรประจำตัวของท่านเพื่อขอความช่วยเหลือ (TTY/TDD: 711)

Ukrainian

Ви маєте право безкоштовно отримати інформацію та допомогу своєю рідною мовою. По допомогу звертайтеся за номером служби підтримки учасників програми страхування, указаним на вашій ідентифікаційній картці. (TTY/TDD: 711)

Urdu

آپ کو اپنی زبان میں مفت ان معلومات اور مدد کے حصول کا حق ہے۔ مدد کے لیے اپنے آئی ڈی کارڈ پر موجود ممبر سروس نمبر کو کال کریں۔ (TTY/TDD:711)

Vietnamese

Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

Yiddish

רופט די מעמבער באדינונגען נומער אויף אייער איר האט די רעכט צו באקומען דעם אינפארמאציע און הילפט אין אייער שפראך בחינם.
(TTY/TDD:711) קארטל פאר הילף

Yoruba

O ní ẹ̀tọ́ láti gba ìwífún yí kí o sì sèrànwọ ní èdè rẹ lọfẹ́ẹ́. Pe Nọmbà àwọn ipèsè ọmọ-ẹgbẹ́ lóri káàdì idánimọ rẹ fún iránwọ. (TTY/TDD: 711)

It's important we treat you fairly

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 Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> . Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>