

 <p>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, https://eoc.empireblue.com/eocdps/fi. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call (800) 342-9816 to request a copy.</p>	
Important Questions	Answers
What is the overall deductible?	\$1,000/single or \$2,500/family for In-Network Providers. \$2,000/single or \$5,000/family for Out-of-Network Providers.
Are there services covered before you meet your deductible?	Yes. Preventive care for In-Network Providers.
Are there other deductibles for specific services?	Yes. \$100/person for In-Network Providers for Prescription Drug. There are no other specific deductibles.
What is the out-of-pocket limit for this plan?	\$5,000/single or \$12,500/family for In-Network Providers. \$14,500/single or \$36,250/family for Out-of-Network Providers.
What is not included in the out-of-pocket limit?	Premiums, Balance-Billing charges, and Health Care this plan doesn't cover.
Will you pay less if you use a network provider?	Yes, Blue Card PPO. See www.empireblue.com or call (800) 342-9816 for a list of network providers.
<p>Why This Matters:</p> <p>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</p> <p>This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.</p> <p>You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.</p> <p>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</p> <p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p> <p>This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider</p>	

for some services (such as lab work). Check with your provider before you get services.

You can see the specialist you choose without a 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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 / visit	50% coinsurance	none
	Specialist visit	\$40 / visit	50% coinsurance	none
If you have a test	Preventive care / screening / immunization	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	none
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.[insert]	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	none
	Tier 1 - Typically Generic	\$10 / prescription pharmacy deductible does not apply (retail) and \$20 / prescription pharmacy deductible does not apply (home delivery)	Not covered	
	Tier 2 - Typically Preferred / Brand	\$35 / prescription, Prescription Drug deductible applies (retail) and \$70 / prescription, Prescription Drug deductible applies (home delivery)	Not covered	*See <u>Prescription Drug</u> section for.
National	Tier 3 - Typically Non-Preferred / Specialty Drugs	\$70 / prescription, Prescription Drug deductible applies (retail) and \$140 / prescription, Prescription Drug	Not covered	

* For more information about limitations and exceptions, see plan or policy document at <https://eoc.empireblue.com/eocdps/fi>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Tier 4 - Typically Specialty (brand and generic)	deductible applies (home delivery)	Not Applicable	-----none-----
	Facility fee (e.g., ambulatory surgery center)	Not Applicable	Not Applicable	-----none-----
If you need immediate medical attention	Physician/surgeon fees	20% coinsurance	50% coinsurance	Copay waived if admitted within 24 hours.
	Emergency room care	20% coinsurance	Covered as In-Network	-----none-----
If you have a hospital stay	Emergency medical transportation	\$150/visit	Covered as In-Network	-----none-----
	Urgent care	20% coinsurance	Covered as In-Network	-----none-----
If you need mental health, behavioral health, or substance abuse services	Facility fee (e.g., hospital room)	\$40/visit	50% coinsurance	-----none-----
	Physician/surgeon fees	20% coinsurance	50% coinsurance	-----none-----
If you are pregnant	Outpatient services	Office Visit \$25/visit Other Outpatient 20% coinsurance medical deductible does not apply	Office Visit 50% coinsurance Other Outpatient 50% coinsurance	Office Visit -----none----- Other Outpatient -----none-----
	Inpatient services	20% coinsurance	50% coinsurance	-----none-----
If you need help recovering or have other special health needs	Office visits	20% coinsurance	50% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	100 visits/benefit period.
If you need help recovering or have other special health needs	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	*See Therapy Services section
	Home health care	20% coinsurance medical deductible does not apply	50% coinsurance medical deductible does not apply	90 days limit/benefit period for In-Network Providers.
If you need help recovering or have other special health needs	Rehabilitation services	20% coinsurance	Not covered	-----none-----
	Habilitation services	20% coinsurance	Not covered	-----none-----
If you need help recovering or have other special health needs	Skilled nursing care	20% coinsurance	Not covered	-----none-----
	Durable medical equipment	50% coinsurance medical deductible does not apply	Not covered	-----none-----
If you need help recovering or have other special health needs	Hospice services	20% coinsurance	Not covered	-----none-----

* For more information about limitations and exceptions, see **plan** or policy document at <https://eoc.empireblue.com/eocdps/fi>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	\$5/visit	\$30 allowance	*See Vision Services section *See Dental Services section
	Children's glasses	\$115 Allowance	\$64 allowance	
	Children's dental check-up	Not covered	Not covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Weight loss programs
- Dental care (adult)
- Hearing aids
- Private-duty nursing
- Dental Check-up
- Routine foot care unless you have been diagnosed with diabetes
- Cosmetic surgery
- Glasses for a child
- Long-term care

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

- Chiropractic care
- Acupuncture
- Infertility treatment
- Routine eye care (adult)
- Bariatric surgery

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 Labor's Employee Benefits Security Administration at (866) 444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

ATTN: Grievances and Appeals, P.O. Box 1407, Church Street Station, New York, NY 10008-1407

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform

New York State Department of Financial Services, One State Street, New York, NY 10004-1511, (800) 342-3736, (212) 480 6400, (518) 474-6600

* For more information about limitations and exceptions, see plan or policy document at <https://eoc.empireblue.com/eocdps/fi>.

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.

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

* For more information about limitations and exceptions, see plan or policy document at <https://eoc.empireblue.com/eocdps/fi>.

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 plan's overall deductible \$1,000
- Specialist copayment \$40
- Hospital (facility) coinsurance 20%
- Other coinsurance 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*)

Total Example Cost \$12,840

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$90
Coinsurance	\$2,480
Limits or exclusions	\$60
The total Peg would pay is	\$3,630

What isn't covered

Managing Joe's type 2 Diabetes

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

- The plan's overall deductible \$1,000
- Specialist copayment \$40
- Hospital (facility) coinsurance 20%
- Other coinsurance 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*)

Total Example Cost \$7,460

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$3,170
Coinsurance	\$27
Limits or exclusions	\$21
The total Joe would pay is	\$4,218

What isn't covered

Mia's Simple Fracture

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

- The plan's overall deductible \$1,000
- Specialist copayment \$40
- Hospital (facility) coinsurance 20%
- Other coinsurance 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*)

Total Example Cost \$2,010

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$570
Coinsurance	\$286
Limits or exclusions	\$0
The total Mia would pay is	\$1,856

What isn't covered

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 (800) 342-9816

Amharic (ፊርማ)፡ ለምን ለሆኑት ጥያቄዎች ወይንም ለሌሎች ጥያቄዎች ከዚህ በፊት ጋር እንደተቆይተው በስራ ላይ ለሆኑት ጥያቄዎች ይከታተሉ ። (800) 342-9816 ።

(800) 342-9816 على اتصال مع مترجم، اتصل على (800) 342-9816. للمساعدة والمعلومات بلغة دون مقابل. للتحدث إلى مترجم، اتصل على (800) 342-9816. Arabic

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և անդեկապություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար ցանկապես հեռախոսահամարով (800) 342-9816:

Bassa (Bàsɔ̀ Wùdù): M̄ d̄yi d̄yi-d̄iè-d̄é-d̄é f̄á c̄éè-d̄é n̄à ke d̄yí n̄í, ɔ̀ mò n̄í d̄yí-f̄é-d̄é-in-d̄é f̄é n̄í ké gbo-kpá-kpá kè b̄ò kp̄ò d̄é n̄ f̄í-d̄í-wùdù n̄ b̄ó pí-d̄yí. Bè n̄ ké wudù-zìin-nyò d̄ò gbo wùdù ke, dá (800) 342-9816.

Bengali (বাংলা): যদি এই নথিপত্র বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিশাল সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দাতাধীর সাথে কথা করার জন্য (৮০০) ৩৪২-৯৮১৬ - (৩ কক্ষ করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဇန်နဝါရီလ (၈၀၀) ၃၄၂-၉၈၁၆ သို့ ခေါ်ဆိုပါ။

Chinese (中文) : 如果你有關於這份文件的任何問題，請撥打免費熱線 (800) 342-9816。

Dinka (Dinka): Na naṅ thiēc né ke de yā thoré, ke yin naṅ loṅ bē yi kuony ku wēr aléu bē gèer. vic yin ne thoṅ du ke cin wēu tāuē ke piny. Te kor yin ba jam wēnē ran ye thok geyic, ke yin col (800) 342-9816.

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 (800) 342-9816.

Farsi (فارسی): 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 شما، با شماره (800) 342-9816 تماس بگیرید.

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (800) 342-9816.

Language Access Services:

- German (Deutsch):** Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (800) 342-9816.
- Greek (Ελληνικά):** Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (800) 342-9816.
- Gujarati (ગુજરાતી):** જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (800) 342-9816.
- Haitian Creole (Kreyòl Ayisyen):** Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (800) 342-9816.
- Hindi (हिंदी):** अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको नि:शुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (800) 342-9816 ।
- Hmong (White Hmong):** Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (800) 342-9816.
- Igbo (Igbo):** O bur u na i nwere ajuju o bula gbasara akwukwo a, i nwere ikike inweta enyemaka na ozi n'asusu gi na akwughi ugwo o bula. Ka gi na okwowa okwu kwuo okwu, kpoo (800) 342-9816.
- Ilokano (Ilokano):** Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (800) 342-9816.
- Indonesian (Bahasa Indonesia):** Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (800) 342-9816.
- Italian (Italiano):** In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (800) 342-9816.
- Japanese (日本語):** この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(800) 342-9816 にお電話ください。

Language Access Services:

Khmer (ខ្មែរ): បើអ្នកមានបំណងផ្សេងទៀតអំពីករណីនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាការសរសេរអ្នកដោយឥតគិតថ្លៃ។
ដើម្បីជ្រកកម្មអ្នកបកប្រែ សូមហៅ (800) 342-9816 ។

Kirundi (Kirundi): Ugize ikibazo icyo arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (800) 342-9816.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (800) 342-9816 로 문의하십시오.

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄຳຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຄູ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.
ເພື່ອໂຮ້ວມກັບວ່າມແປພາສາ, ໃຫ້ໃບຫາ (800) 342-9816.

Navajo (Diné): Dii naaltsoos bika' igit' ighi' kahgo bina' idil'ikidgo ná bohónéedz'á dóó bee ahóót'í' t'áá ni nizaad k'ehjí bee níí hodoomih t'áadoo bááh' íliníg'óó.
Aha' balné' igit' la' bich'í' hadeesdzih' níinízingo kojí' hodíílmih' (800) 342-9816.

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 (800) 342-9816

Oromo (Oromifaa): Sanadi kanaa wajjin walqabaate gaffi kamiyyu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (800) 342-9816 bilbilla.

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