**Summary of Benefits and Coverage:** What this **Plan** Covers & What You Pay For Covered Services **Coverage Period: 07/01/2017– 06/30/2018**

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| **State of Maine Health Plan: PPO** | **Coverage for:** Individual + Family | **Plan Type: PPO** |

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| image2 | **The Summary of Benefits and Coverage (SBC) document will help you choose a health** [**[plan](https://www.healthcare.gov/sbc-glossary/)**](https://www.healthcare.gov/sbc-glossary/)**. The SBC shows you how you and the** [[**plan**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) **would share the cost for covered health care services. NOTE: Information about the cost of this** [[**plan**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) **(called the** [**[premium](https://www.healthcare.gov/sbc-glossary/)**](https://www.healthcare.gov/sbc-glossary/)**) 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://www.maine.gov/deh/>. For general definitions of common terms, such as [[allowed amount](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/), [[balance billing](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/), [[coinsurance](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/), [[copayment](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/), [[deductible](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/), [[provider](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/), 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 (844) 273-4614 to request a copy. | |

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| **Important Questions** | **Answers** | **Why This Matters:** |
| **What is the overall deductible?** | **$600**/individual or **$1,200**/family for Preferred and In-Network Providers. **$3,000**/individual or **$6,000**/family for Out-of-Network Providers. | 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. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care for Preferred Providers. Preventive care for In-Network Providers. | 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/>](https://www.healthcare.gov/coverage/preventive-care-benefits/). |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the** **out-of-pocket limit for this plan?** | **$2,000**/individual or **$4,000**/family for Preferred and In-Network Providers. **$5,000**/individual or **$10,000**/family for Out-of-Network Providers. | 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. |
| **What is not included in the out-of-pocket limit?** | Prescription Drugs, Premiums, Balance-Billing charges, and Health Care this plan doesn't cover. | Even though you pay these expenses, they don’t count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes, Blue Choice PPO. See <https://www.anthem.com> or call (844) 273-4614 for a list of network providers. | You pay the least if you use a Preferred provider. You pay more if you use a provider in In-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 for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

| image3 | All [[**copayment**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) and [[**coinsurance**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) costs shown in this chart are after your [[**deductible**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) has been met, if a [[**deductible**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) applies. |
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| **Common**  **Medical Event** | **Services You May Need** | **What You Will Pay** | | | **Limitations, Exceptions, & Other Important Information** |
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| **Preferred Provider**  **(You will pay the least)** | **In-Network Provider**  **(You will pay more)** | **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 | $20/visit | $40/visit | 40% coinsurance | No cost share for screening and counseling services In-Network (e.g. tobacco cessation counseling, nutritional counseling, etc.). |
| Specialist visit | n/a | $40/visit | 40% coinsurance | Specialist In-Network copayment for mental health, behavioral health and substance abuse services $20. (See page 3.)  Chiropractic visits limited to 25 visits per calendar year. |
| Preventive care**/**screening**/**  immunization | No charge | No charge | 40% coinsurance | Mammogram (screening & medically necessary; 2D & 3D): No cost share for Out-of-Network Providers.  Colonoscopy (screening & medically Necessary): 40% coinsurance for Out-of-Network Providers.  Hepatitis C virus screening test for people at high risk for infection and a one-time screening test for adults born between 1945 and 1965.  You may have to pay for services that aren't preventive. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 10% coinsurance | 20% coinsurance | 40% coinsurance | --------none-------- |
| Imaging (CT/PET scans, MRIs) | 10% coinsurance | 20% coinsurance | 40% coinsurance | --------none-------- |
| **If you need drugs to treat your illness or condition**  More information about **prescription drug coverage** is available at [www.maine.gov/deh](http://www.maine.gov/deh). | Tier 1 - Typically Generic | $10 copay/prescription for up to a 30 day supply  $15 copay/prescription for up to a 90 day supply | $10 copay/prescription for up to a 30 day supply  $15 copay/prescription for up to a 90 day supply | $10 copay/prescription for up to a 30 day supply  $15 copay/prescription for up to a 90 day supply | Up to a 90 day supply is allowed at retail pharmacies.  Non-Participating pharmacies, you are required to pay 100% of the medication cost and then submit for reimbursement.  Certain medications identified under Health Care Reform will be covered with no cost to the member.  Lifestyle medications (impotency/fertility) are covered at $50 copay for a 30 day supply and $75 for 90 day supply.  Prescription out-of-pocket maximum limits are $4,600 (Individual) and $9,200 (Family).  Individual lifetime fertility cap: $10,000.  Specialty medications must be filled through Accredo Specialty Pharmacy.  Refer to your plan SPD for full benefit details. |
| Tier 2 - Typically Preferred / Brand | $30 copay/prescription for up to a 30 day supply  $45 copay/prescription for up to a 90 day supply | $30 copay/prescription for up to a 30 day supply  $45 copay/prescription for up to a 90 day supply | $30 copay/prescription for up to a 30 day supply  $45 copay/prescription for up to a 90 day supply |
| Tier 3 - Typically Non-Preferred | $45 copay/prescription for up to a 30 day supply  $70 copay/prescription for up to a 90 day supply | $45 copay/prescription for up to a 30 day supply  $70 copay/prescription for up to a 90 day supply | $45 copay/prescription for up to a 30 day supply  $70 copay/prescription for up to a 90 day supply |
| Tier 4 - Typically Specialty Drugs | 25% coinsurance ($150 max) for up to a 30 day supply  25% coinsurance ($225 max) for up to a 90 day supply | 25% coinsurance ($150 max) for up to a 30 day supply  25% coinsurance ($225 max) for up to a 90 day supply | 25% coinsurance ($150 max) for up to a 30 day supply  25% coinsurance ($225 max) for up to a 90 day supply |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 20% coinsurance | 40% coinsurance | 5% coinsurance for designated ambulatory surgery center. |
| Physician/surgeon fees | 10% coinsurance | 20% coinsurance | 40% coinsurance | --------none-------- |
| **If you need immediate medical attention** | Emergency room care | $300/visit | $300/visit | Covered as In-Network | If admitted inpatient, ER copay is waived. |
| Emergency medical transportation | 10% coinsurance | 10% coinsurance | Covered as In-Network | --------none-------- |
| Walk-In Center | $25/visit | $25/visit | 40% coinsurance | Copay applies when members use a designated walk-in center. Brighton First Care in Portland, ME is not considered a walk-in center; the copay for this facility would be $300. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% coinsurance | 20% coinsurance | 40% coinsurance | --------none-------- |
| Physician/surgeon fees | 10% coinsurance | 20% coinsurance | 40% coinsurance | --------none-------- |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office Visit $20/visit  Other Outpatient  10% coinsurance | Office Visit  $20/visit  Other Outpatient  20% coinsurance | Office Visit  40% coinsurance  Other Outpatient  40% coinsurance | Office Visit  --------none--------  Other Outpatient  --------none-------- |
| Inpatient services | 10% coinsurance | 20% coinsurance | 40% coinsurance | --------none-------- |
| **If you are pregnant** | Office visits | 10% coinsurance | 20% coinsurance | 40% coinsurance | Post-admission review, you, a family member, your physician, or the provider should call if the hospital stay exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean section. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
| Childbirth/delivery professional services | 10% coinsurance | 20% coinsurance | 40% coinsurance |
| Childbirth/delivery facility services | 10% coinsurance | 20% coinsurance | 40% coinsurance |
| **If you need help recovering or have other special health needs** | Home health care | 10% coinsurance | 20% coinsurance | 40% coinsurance | --------none-------- |
| Rehabilitation services | $40/visit | $40/visit | 40% coinsurance | \*See Therapy Services section |
| Habilitation services | $40/visit | $40/visit | 40% coinsurance |
| Skilled nursing care | 10% coinsurance | 20% coinsurance | 40% coinsurance | 100 days limit/benefit period. |
| Durable medical equipment | 10% coinsurance | 10% coinsurance | 40% coinsurance | --------none-------- |
| Hospice services | 10% coinsurance | 20% coinsurance | 40% coinsurance | --------none-------- |
| **If your child needs dental or eye care** | Children’s eye exam | No charge | No charge | 40% coinsurance | \*See Vision Services section of plan booklet |
| Children’s glasses | Not covered | Not covered | Not covered |
| Children’s dental check-up | Not covered | Not covered | Not covered | \*See Dental Services section of plan booklet |

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| **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](https://www.healthcare.gov/sbc-glossary/)**](https://www.healthcare.gov/sbc-glossary/).**)** |
| |  |  |  | | --- | --- | --- | | * Cosmetic surgery | * Dental care (adult) | * Long- term care | | * Private-duty nursing | * Routine foot care unless you have been diagnosed with diabetes. | * Weight loss programs | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |

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| **Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)** |
| |  |  |  | | --- | --- | --- | | * Acupuncture * Hearing aids one hearing aid for each hearing impaired ear every 36 months through age 18. | * Bariatric surgery * Infertility treatment $10,000 medical maximum/lifetime and $10,000 prescription maximum/lifetime. | * Chiropractic care 25 visits/member/calendar year. * Most coverage provided outside the United States. See [www.bcbsglobalcore.com](https://www.bcbsglobalcore.com) | | * Routine eye care/one routine eye exam/calendar year. |  |  | |  |  |  | |  |  |  | |  |  |  | |

**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:** There are agencies that can help if you have a complaint against your [[plan](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) for a denial of a [[claim](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/). 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 218, North Haven, CT 06473-0218

**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:**

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| image4 | **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. |

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| **Peg is Having a Baby**  (9 months of in-network pre-natal care and a hospital delivery) | |  | **Managing Joe’s type 2 Diabetes**  (a year of routine in-network care of a well- controlled condition) | |  | **Mia’s Simple Fracture**  (in-network emergency room visit and follow up care) | |
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|  **The** [[**plan’s**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) **overall** [[**deductible**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) | **$600** |  |  **The** [[**plan’s**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) **overall** [[**deductible**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) | **$600** |  |  **The** [[**plan’s**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) **overall** [[**deductible**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) | **$600** |
|  [[**Specialist**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) ***copayment*** | **$40** |  |  [[**Specialist**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) ***copayment*** | **$40** |  |  [[**Specialist**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) ***copayment*** | **$40** |
|  **Hospital (facility) *coinsurance*** | **10%** |  |  **Hospital (facility) *coinsurance*** | **10%** |  |  **Hospital (facility) *coinsurance*** | **10%** |
|  **Other** ***coinsurance*** | **10%** |  |  **Other** ***coinsurance*** | **10%** |  |  **Other** ***coinsurance*** | **10%** |
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| **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)* | |  | **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)* | |  | **This EXAMPLE event includes services like:**  **Emergency room care** *(including medical supplies)*  **Diagnostic test** *(x-ray)*  **Durable medical equipment** *(crutches)*  **Rehabilitation services** *(physical therapy)* | |
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| **Total Example Cost** | **$12,840** |  | **Total Example Cost** | **$7,460** |  | **Total Example Cost** | **$2,010** |
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| **In this example, Peg would pay:** |  |  | **In this example, Joe would pay:** |  |  | **In this example, Mia would pay:** |  |
| ***Cost Sharing*** | |  | ***Cost Sharing*** | |  | ***Cost Sharing*** | |
| **Deductibles** | $600 |  | **Deductibles** | $600 |  | **Deductibles** | $600 |
| **Copayments** | $40 |  | **Copayments** | $200 |  | **Copayments** | $1,120 |
| **Coinsurance** | $1,240 |  | **Coinsurance** | $13 |  | **Coinsurance** | $86 |
| *What isn’t covered* | |  | *What isn’t covered* | |  | *What isn’t covered* | |
| Limits or exclusions | $60 |  | Limits or exclusions | $21 |  | Limits or exclusions | $0 |
| **The total Peg would pay is** | **$1,940** |  | **The total Joe would pay is** | **$834** |  | **The total Mia would pay is** | **$1,806** |

**(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 (844) 273-4614

**Amharic (አማርኛ)፦** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (844) 273-4614 ይደውሉ።

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| .(844) 273-4614 | image5 |

**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՝ (844) 273-4614:

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| image6 | |
| image7 | (844) 273-4614. |

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| image9 | (844) 273-4614 | image10 |

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| image11 | | |
| image12 | (844) 273-4614 | image13 |

**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 (844) 273-4614。

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| image14 | |
| image15 | (844) 273-4614. |

**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 (844) 273-4614.

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| image16 | | |
| image17 | (844) 273-4614 | image18 |
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**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 (844) 273-4614.

**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 (844) 273-4614.

**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 (844) 273-4614.

**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 (844) 273-4614.

**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 (844) 273-4614.

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| image19 | | |
| image20 | (844) 273-4614 | image21 |

**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 (844) 273-4614.

**Igbo (Igbo):** Ọ bụr ụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (844) 273-4614.

**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 (844) 273-4614.

**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 (844) 273-4614.

**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 (844) 273-4614

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| image22 | | |
| image23 | (844) 273-4614 | image24 |

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| image26 | (844) 273-4614 | image27 |

**Kirundi (Kirundi):** Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (844) 273-4614.

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**Oromo (Oromifaa):** Sanadi kanaa wajiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (844) 273-4614 bilbilla.

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**Samoan (Samoa):** Afai e iai ni ou fesili e uiga i lenei tusi, e iai lou ‘aia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se totogi. Ina ia talanoa i se tagata faaliliu, vili (844) 273-4614.

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