2020-2021

Colorado School of Mines
Student Health Insurance Plan

www.anthem.com/studentadvantage

Anthem Student Advantage
Keeping you at your personal best

A00312COMENABS 08/20

Anthem | STUDENT ADVANTAGE

Important notice

This is a brief description of your student health plan underwritten by Anthem Blue Cross and Blue Shield (Anthem). If you would like more details about your coverage and costs, you can find the complete terms in the policy or plan document online at anthem.com or csm.myahpcare.com.

Table of contents

Welcome to Anthem Student Advantage

As your new school year begins, it's important to understand your health care benefits and how they work.

Your Anthem Student Advantage plan can help keep you at your personal best. This book will guide you through your plan benefits, with information about who is eligible, what is covered, how to access the right type of care when you need it, and more.

What you need to know about Anthem Student Advantage

Who is eligible?

- All degree-seeking students, regardless of credit hours must purchase the Student Health Insurance Plan, unless they meet specific requirements to waive.
- All International Students (F and J visas), regardless of degree-seeking status, must purchase the Student Health Insurance Plan, unless they meet specific requirements to waive. This requirement applies to all International Students (excludes International Scholars who have been awarded research, teaching or faculty appointments). International students who have government, embassy or US-based company sponsorships may be able to complete a waiver to opt out of the SHIP. (International policies MUST have a United States claims address and contact phone number to be approved for a waiver).
- Please view the complete brochure online at csm.myahpcare.com for full details of participation in the plan.

*The above rates include premiums for the plan and commissions and administrative fees.
*Rates are pending approval with the state and subject to change.

Coverage periods and rates

Coverage will become effective at 12:01 a.m., and will end at 11:59 p.m. on the dates shown below.

Costs and dates of coverage

The coverage provided with respect to the Covered Person shall terminate at 07/31/2021 at 11:59 p.m. standard time on the earliest of the following dates:

- The date the Policy terminates for all insured persons; or
- The end of the period of coverage for which premium has been paid; or
- The date an Insured Person ceases to be eligible for the insurance; or
- The date an Insured Person enters military service.

You must meet the eligibility requirements listed herein each time you pay a premium to continue insurance coverage.
Refunds of premium are allowed only upon entry into the Armed Forces, and the Company receives proof of active duty.
The SHIP does not offer dependent coverage.

Medical	Annual 8-1-20 through 7-31-21	Spring/Summer 1-1-21 through 7-31-21	Summer 5-17-21 through 7-31-21
Student	$2,450.00	$1,423.00	$510.00

*The above rates include premiums for the plan and commissions and administrative fees.
*Rates are pending approval with the state and subject to change.

Important dates for the coverage period

Open enrollment

› Annual
July 15, 2020 – September 9, 2020

Waiver deadlines

You can waive your Anthem Student Advantage if you have comparable coverage.

Annual
July 15, 2020 – September 9, 2020

If you have **questions about enrollment and waiver options,** email SHIP@mines.edu.

Keep in touch with your benefits information

Eligibility, enrollment, and waiver questions

Colorado School of Mines SHIP
ship@mines.edu
1-303-273-3388

Claims and coverage

1-844-412-0752
Anthem Blue Cross Life and Health Insurance Company
PO Box 5747
Denver, CO 80217

Student Health Center

Coulter Student Health Center
W. Lloyd Wright Wellness Center
1770 Elm St.
Golden, CO 80401
1-303-273-3381
FAX 1-303-273-3623
shc@mines.edu

Monday-Friday: 8 am – noon and 1 pm – 4:45 pm
Please call to schedule an appointment.

Easy access to care

Access the care you need, in the way that works best for you.

Sydney Health app

With the Sydney Health[1] app through Anthem Student Advantage, you have instant access to:

- Your member ID card.
- The Find a Doctor tool.
- More information about your plan benefits.
- Health tips that are tailored to you.
- LiveHealth Online and 24/7 NurseLine.
- Student support specialists (through click-to-chat or by phone).

Access the Sydney Health app

Go to the App Store℠ or Google Play™ and search for the Sydney Health app to download it today.

LiveHealth Online

From your mobile device or computer with a webcam, you can use LiveHealth Online to visit with a board-certified doctor, psychiatrist or licensed therapist through live video.[2] To use, go to your Sydney Health app or livehealthonline.com. You can also download the free LiveHealth Online app to sign up.

24/7 NurseLine

Call **1-844-545-1429** to speak to a registered nurse who can help you with health issues like fever, allergy relief, cold and flu symptoms and where to go for care. Nurses can also help you enroll in health management programs if you have specific health conditions, remind you about scheduling important screenings and exams, and more.

Provider finder

Visit www.anthem.com/find-care to find the right doctor or facility close to where you are.

Anthem Student Advantage Colorado School of Mines website

Visit www.anthem.com/studentadvantage or csm.myahpcare.com to see your health plan information, including providers, benefits, claims, covered drugs and more.

1 Sydney Health is a service mark of CareMarket, Inc.
2 Appointments subject to availability of a therapist. Psychologists or therapists using LiveHealth Online cannot prescribe medications. Online counseling is not appropriate for all kinds of problems. If you are in crisis or have suicidal thoughts, it's important that you seek help immediately. Please call 1-800-784-2433 (National Suicide Prevention Lifeline) or 911 and ask for help. If your issue is an emergency, call 911 or go to your nearest emergency room. LiveHealth Online does not offer emergency services.
LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of Anthem Blue Cross and Blue Shield.

Your summary of benefits

Anthem Blue Cross and Blue Shield

Student Health Insurance Plan:
Colorado School of Mines

Your network:
PPO

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC) will prevail. Plan benefits are pending approval with the state and subject to change.

Medical

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.*	$0 student	$1,000 student
Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost- shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.*	$2,000 student	$4,000 student
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible. Out-of-Network preventive care services for children prior to their 6th birthday have no deductible.*	No charge	40% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Office Visit to treat an injury or illness	$25 copay per visit deductible does not apply	$25 copay per visit 40% coinsurance deductible does not apply
Specialist Care Office Visit	$25 copay per visit deductible does not apply	$25 copay per visit 40% coinsurance deductible does not apply
Prenatal and Post-natal Care	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	$25 copay per visit deductible does not apply	40% coinsurance after deductible is met
On-line Visit *Live Health Online is the preferred telehealth solutions (www.livehealthonline.com)*	$25 copay per visit deductible does not apply	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Manipulation Therapy *Coverage is limited to 20 visits per benefit period. Limit is combined In-Network and Out-of-Network across all outpatient settings.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Acupuncture	See 'Therapy Services"	See 'Therapy Services"
Other Services in an Office:		
Allergy Testing	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Chemo/Radiation Therapy	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Hemodialysis	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Prescription Drugs *For the drugs itself dispensed in the office through infusion/ injection.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Diagnostic Services		
Lab:		
Office *Office Cost Share applies only when Freestanding/Reference Labs are not used.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Lab/Reference Lab	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
X-Ray:		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care (Office Setting)	$35 copay per visit and 20% coinsurance deductible does not apply	$35 copay per visit 40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Emergency Room Facility Services *Copay waived if admitted*	$100 copay per visit and 20% coinsurance, deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after deductible is met	Covered as In-Network
Ambulance (Air and Water) For Emergency ambulance services from an Out-of-Network Provider you do not need to pay any more than you would have paid for services from an In-Network Provider. **Important Note:** Air ambulance services for non-Emergency Hospital to Hospital transfers must be approved through Precertification. Please see the section "How to Access Your Services and Obtain Approval of Benefits" in the Policy for details.	0% coinsurance after deductible is met	Covered as In-Network
Ambulance (Ground) For Emergency ambulance services from an Out-of-Network Provider you do not need to pay any more than you would have paid for services from an In-Network Provider. **Important Note:** All scheduled ground ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through Precertification. Please see the section "How to Access Your Services and Obtain Approval of Benefits" in the Policy for details.	0% coinsurance after deductible is met	Covered as In-Network
Autism Services Includes Applied Behavioral Analysis Services The limits for physical, occupational, and speech therapy will not apply to children between age 3 and 6 with Autism Spectrum Disorders, if part of a Student's Autism Treatment Plan, and determined Medically Necessary by Us.	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Mental Health and Substance Use Disorder		
Doctor Office Visit	$25 copay per visit deductible does not apply	$25 copay per visit 40% coinsurance deductible does not apply
Facility visit:		
Facility Fees	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor Services	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Surgery		
Facility fees:		
Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor and Other Services:		
Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Hospital Stay (all Inpatient stays including Maternity, Mental and Substance Use Disorder):		
Facility fees (for example, room & board) *Coverage for Inpatient rehabilitation and skilled nursing services combined In-Network Providers and Out-of-Network Providers combined is limited to 60 days per benefit year.*	$250 copay 20% coinsurance deductible does not apply	$750 copay 40% coinsurance deductible does not apply
Hospital Intensive Care Unit Expense *In lieu of normal Hospital Room & Board Expenses*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor and other services	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Care Visits *Coverage for In-Network Providers and Out-of-Network Providers up to 28 hours per week. Visit limit does not apply to Physical, Occupational or Speech Therapy when performed as part of Home Health.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/ occupational therapy):		
Office *Coverage for physical therapy and occupational therapy combined is limited to 20 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Apply to In-Network Providers and Out-of-Network Providers combined. Visit limits are combined both across outpatient and other professional visits.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital *Coverage for physical therapy and occupational therapy combined is limited to 20 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Apply to In-Network Providers and Out-of-Network Providers combined. Visit limits are combined both across outpatient and other professional visits.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Habilitation services (for example, physical/speech/ occupational therapy):		
Office *Coverage for physical therapy and occupational therapy combined is limited to 20 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Apply to In-Network Providers and Out-of-Network Providers combined. Visit limits are combined both across outpatient and other professional visits.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital *Coverage for physical therapy and occupational therapy combined is limited to 20 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Apply to In-Network Providers and Out-of-Network Providers combined. Visit limits are combined both across outpatient and other professional visits.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Cardiac rehabilitation		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Skilled Nursing Care (in a facility) *Coverage for Inpatient rehabilitation and skilled nursing services combined In- Network Providers and Out-of-Network Providers combined is limited to 100 days per benefit period.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Hospice	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Durable Medical Equipment *Coverage for hearing aids services left ear is limited to 1 unit every 48 months and right ear is limited to 1 unit every 48 months for children 18 years of age or under. Coverage is limited to $3,000 per hearing aid. Apply to In-Network Providers and Out-of-Network Providers combined.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs needed after cancer treatment In-Network Providers and Out-of-Network Providers combined is limited to 1 items per benefit period.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Sports Accident Expense *Incurred as the result of the play or practice of Intercollegiate sports up to $90,000 per Accident.*	10% coinsurance after deductible is met	30% coinsurance after deductible is met

Pharmacy

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out of Pocket	Combined with medical out of pocket maximum	Not applicable
Prescription Drug Coverage *Traditional Open Drug List* *This product has a 90-day Retail Pharmacy Network available.* *A 90 day supply is available at most retail pharmacies.*		
Tier 1 - Typically Lower Cost Generic *Covers up to a 30 day supply (retail pharmacy).*	$15 copay per Prescription deductible does not apply (retail only).	Not covered
Tier 2 – Typically Preferred Brand *Covers up to a 30 day supply (retail pharmacy).*	$30 copay per Prescription deductible does not apply (retail only).	Not covered
Tier 3 - Typically Non-Preferred Brand *Covers up to a 30 day supply (retail pharmacy).*	$60 copay per Prescription deductible does not apply (retail only).	Not covered

Vision

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
This is a brief outline of your vision coverage. Not all cost shares for covered services are shown below. Benefits include coverage for student's choice of eyeglass lenses or contact lenses, but not both. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail.		
Adult Vision (age 19 and older)		
Adult Vision Deductible	Not Applicable	Not Applicable
Vision exam	$25 copay	30% coinsurance
Children's Vision (up to age 19)		
Child Vision Deductible	$0 person	Not Applicable
Vision exam *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 exam per benefit period*	No charge	Reimbursed Up to $30
Frames *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $45
Lenses *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.*		
Single vision lenses	$0 copay	$0 copay (up to $25)
Bifocal lenses	$0 copay	$0 copay (up to $45)
Trifocal lenses	$0 copay	$0 copay (up to $55)
Lenticular lenses	$0 copay	$0 copay (up to $70)
Progressive lenses (standard, premium, select, ultra)	$0 copay	$0 copay (up to $40)
Transitions Lenses	$0 copay	Not covered
Standard polycarbonate	$0 copay	Not covered
Factory Scratch Coating	$0 copay	Not covered
Elective contact lenses *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.*	No charge	$0 copay (up to $60)
Non-Elective Contact Lenses *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.*	No charge	$0 copay (up to $210)

Children's Dental Essential Health Benefits (up until age 19)

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
This is a brief outline of your dental coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail. Only children's dental services count towards your out of pocket limit.		
Diagnostic and preventive *Coverage for In-Network Providers and Out-of-Network Providers combined is limited to 2 visits per benefit period.*	No Charge	No Charge
Basic services	20% coinsurance after deductible is met	20% coinsurance after deductible is met
Major services	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Endodontic, Periodontics, Oral Surgery	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Medically Necessary Orthodontia services	50% coinsurance after deductible is met	50% coinsurance after deductible is met

Additional Services and Programs
Anthem Whole Health Connection -Dental
For members with certain health conditions, additional dental benefits are available without a deductible or waiting periods. Eligible services are paid at 100% and won't reduce your coverage year annual maximum (if applicable)
Accidental Dental Injury Benefit
Provides members 100% coverage for accidental injuries to teeth up to the coverage year annual maximum (if applicable). No deductibles, member coinsurance, or waiting periods apply
Extension of Benefits
Following termination of coverage, members are provided up to 60 days to complete treatment started prior to their termination of coverage under the plan and eligible services will be covered
International Emergency Dental Program
Provides emergency dental benefits while working or traveling abroad from licensed, English-speaking dentists. Eligible covered services will be paid 100% with no deductibles, member coinsurance, or waiting periods and won't reduce the member coverage year annual maximum (if applicable)

Additional Limitations & Exclusions. Below is a partial listing of non-covered services under your dental plan. Please see your policy for a full list.

Services provided before or after the term of this coverage - Services received before your effective date or after your coverage ends, unless otherwise specified in the dental plan certificate
Orthodontics (unless included as part of your dental plan benefits) including orthodontic braces, appliances and all related services
Cosmetic dentistry (unless included as part of your dental plan benefits) provided by dentists solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (cavities) exist
Drugs and medications including intravenous conscious sedation, IV sedation and general anesthesia when performed with nonsurgical dental care
A**nalgesia, analgesic agents, and anxiolysis nitrous oxide,** therapeutic drug injections, medicines or drugs for nonsurgical or surgical dental care except that intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.
Waiting periods for endodontic, periodontic and oral surgery services may differ from other Basic Services or Major Services under the same dental plan.
There is a waiting period of up to 24 months for replacement of congenitally missing teeth or teeth extracted prior to coverage under this plan.

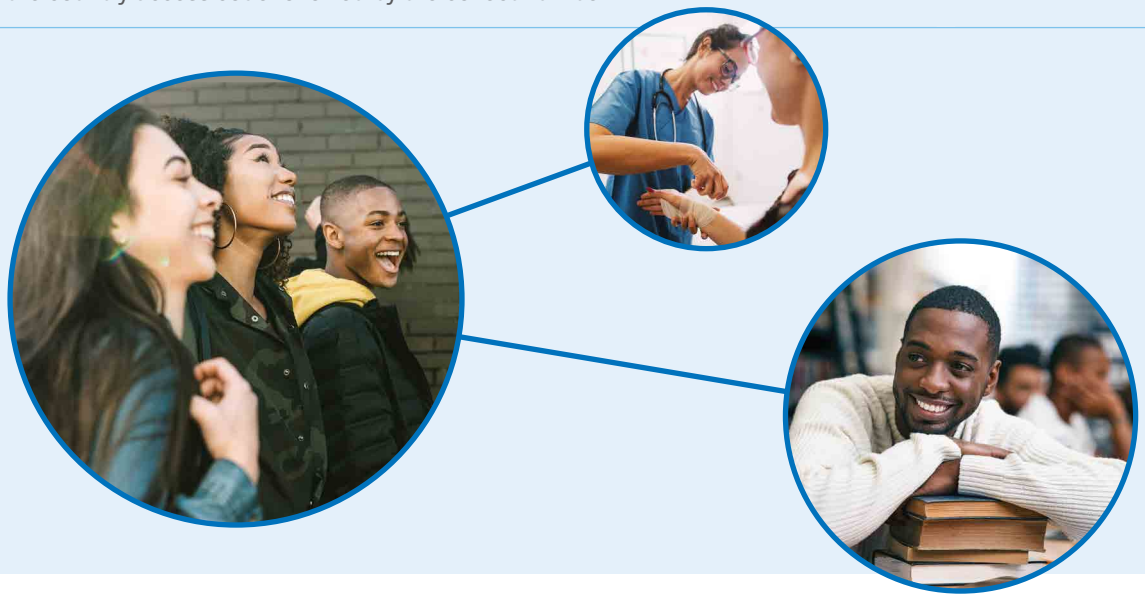
Emergency travel assistance

As a participant in the student health plan, you have access to the emergency travel services and benefits when you are traveling over 100 miles from home or outside your home country.

To ensure you have immediate access to assistance if you experience a travel related crisis:

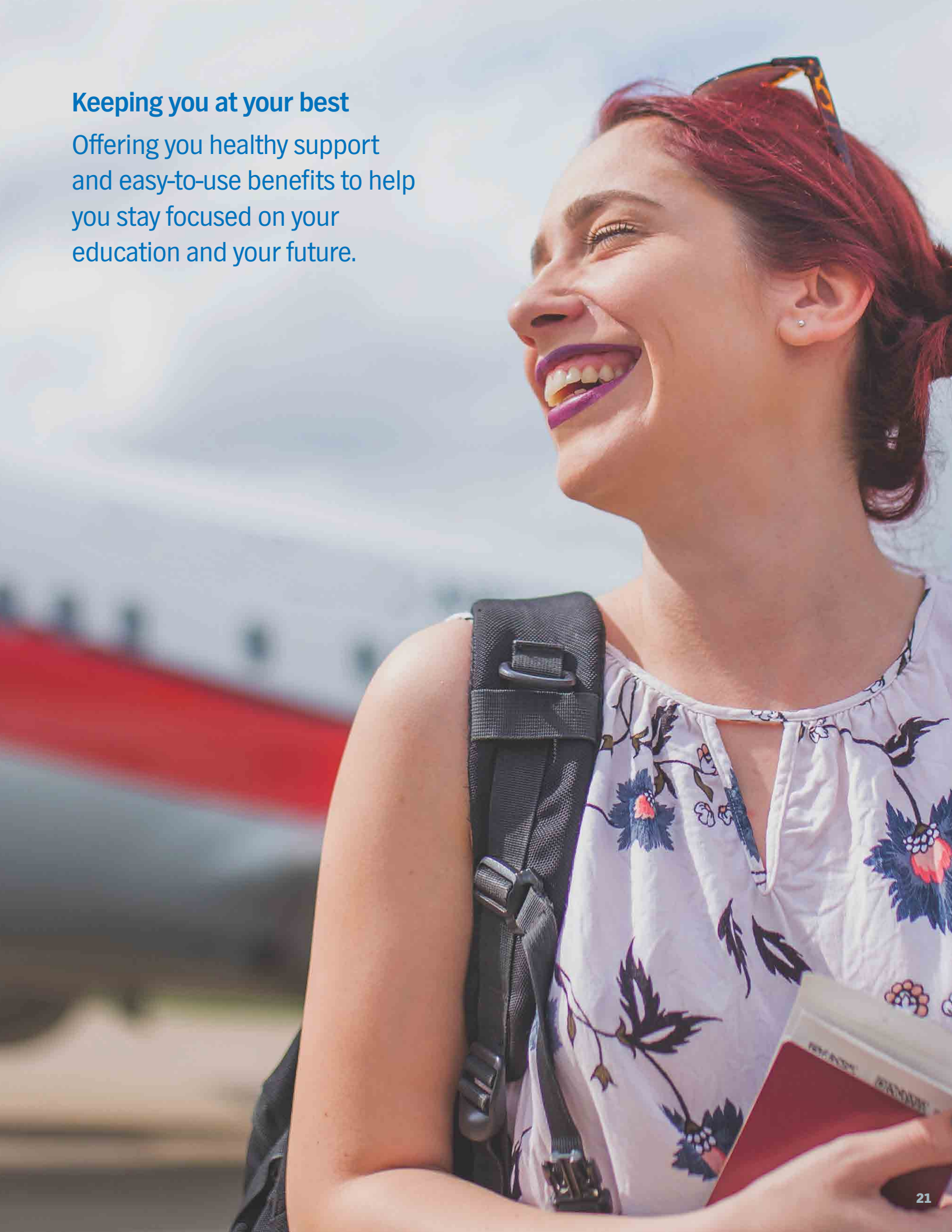
Academic HealthPlans has included Academic Emergency Services (AES) in your Student Health Insurance Plan coverage. AES offers a wide range of services and benefits to provide everything you need to prepare for your international experience, as well as get the help or information you need in a crisis.

Academic Emergency Services Numbers	
To contact Academic Emergency Services from the U.S or Canada, call:	**1-855-873-3555**
To contact Academic Emergency Services from outside the U.S. or Canada, dial the country access code followed by the collect number:	**1-610-263-4660**



Keeping you at your best

Offering you healthy support and easy-to-use benefits to help you stay focused on your education and your future.



Exclusions

Medical: In this section you will find a review of items that are not covered by your Plan. Excluded items will not be covered even if the service, supply, or equipment is Medically Necessary. This section is only meant to be an aid to point out certain items that may be misunderstood as Covered Services. This section is not meant to be a complete list of all the items that are excluded by your Plan. We will have the right to make the final decision about whether services or supplies are Medically Necessary and if they will be covered by your Plan.

Acts of War, Disasters, or Nuclear Accidents; Administrative Charges; Alternative / Complementary Medicine; Charges Over the Maximum Allowed Amount; Cosmetic Services; Court Ordered Testing; Custodial Care; Experimental or Investigational Services; Eyeglasses and Contact Lenses; Health Club Memberships and Fitness Services; Non-Medically Necessary Services; Nutritional or Dietary Supplements; Personal Care and Convenience Items; Private Duty Nursing; Stand-By Charges; Travel Costs; Vision Services; Weight Loss Programs.

Pharmacy: In addition to the above Exclusions, certain items are not covered under the Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy benefit: Clinically-Equivalent Alternatives; Compound Drugs; Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications; Drugs That Do Not Need a Prescription; Lost or Stolen Drugs; Non-approved Drugs; Nutritional or Dietary Supplements; Off label use; Over-the-Counter Items; Weight Loss Drugs.

Access help in your language

If you have any questions about this document, you have the right to help and information in your language at no cost. To talk to an interpreter, call (844) 412-0752.

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card. (TTY/TDD: 711)

Arabic

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

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)

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)

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)

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)

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)

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)

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)

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)

Punjabi

ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (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)

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)

Tagalog

May karapatan kayong makakuha 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)

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)

It is important we treat you fairly

That is why we follow federal civil rights laws in our health programs and activities. We do not 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 is not English, we offer free language assistance services through interpreters and other written languages. If you are interested in these services, call the Customer Service 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. You can also 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.

If you have questions, call 1-303-273-3388 or email ship@mines.edu.

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