2021-2022

Oberlin College and Conservatory
Student Health Insurance Plan

www.anthem.com/studentadvantage

Anthem Student Advantage
Keeping you at your personal best

A003110HMENABS 06/21

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.

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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 will help guide you through that process with information about who is eligible, what is covered, how much it costs, and the best ways to access care.

What you need to know about Anthem Student Advantage

Who is eligible?

- All full time students enrolled at Oberlin College are automatically enrolled in the Student Health Insurance Plan
- The premium cost is included on the tuition bill unless proof of comparable coverage is provided by the waiver deadline.
- All part-time and senior students completing their remaining credits to graduate and who have permission from the college are eligible to enroll in the Student Health Insurance Plan on a voluntary basis.
- To waive online, log onto oberlin.myahpcare.com/waiver.

Coverage is available for dependents too

Here is how it works:

- If you are covered by the Student Health Insurance Plan for Oberlin College and Conservatory University, you may also enroll your lawful spouse and/or dependent children under the age of 26.
- To enroll eligible dependent(s) of a covered student, please visit oberlin.myahpcare.com during the open enrollment period.

*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

Medical	Annual 8-1-2021 through 7-31-2022	Spring/Summer 2-1-2022 through 07-31-2022
Student (tuition billed)	$2,184	$1,092
Spouse	$2,184	$1,092
Each Child	$2,117	$1,058.50

The child rate is up to two children. The cost for two or more children will be two times the child rate.

*The above rates include premiums for the plan and commissions and administrative fees.

Important dates for the coverage period

Open enrollment

- Annual:
  7/7/2021 – 8/20/2021
- Spring/Summer:
  12/3/2021 - 2/18/2022

Waiver deadlines

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

- Annual:
  7/7/2021 – 08/20/2021
- Spring/Summer:
  12/3/2021 - 2/18/2022

If you have **questions about enrollment and waiver options,** visit oberlin.myahpcare.com/waiver.

Keep in touch with your benefits information

Student Health Center

Oberlin Student Health Services
247 W. Lorain St.
Oberlin, OH 44074
1-440-775-8180
student.health@oberlin.edu

Monday-Friday: 8:30 a.m.-4:30 p.m.
Closed daily from 1-2 p.m.
Closed Thursdays from 2-3 p.m.

Walk-in Hours
Monday-Friday: 11 a.m. -12:30 p.m.
Wednesdays: 9 a.m.-12:30 p.m. and
2p.m. -3:45 p.m.

Claims and coverage

1-844-412-0752
Anthem Blue Cross Life and Health
Insurance Company
PO Box 105187
Atlanta GA 30348-5187

Benefits, eligibility and enrollment

Academic HealthPlans
oberlin.myahpcare.com
P.O. Box 1605
Colleyville, TX 76034

Easy access to care

Access the care you need, when you need it, and 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 Oberlin College and Conservatory website

Visit www.anthem.com/studentadvantage 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:
Oberlin College and Conservatory

Your network:
BlueChoice Open Access POS

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		
The deductible is waived at Mercy Medical Center.	$250 person	$500 person
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.	$6,000 person $17,100 family	$6,000 person $17,100 family
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	$20 copay	40% coinsurance after deductible is met
Specialist Care Office Visit	$20 copay	40% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	$20 copay	40% coinsurance after deductible is met
On-line Visit *Live Health Online is the preferred telehealth solutions*	$20 copay	40% coinsurance after deductible is met
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	Not covered	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
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)	$50 copay per visit and 20% coinsurance deductible does not apply	Covered as In-Network
Emergency Room Facility Services *Copay waived if admitted*	$200 copay per visit and 20% coinsurance	Covered as In-Network
Emergency Room Doctor and Other Services	$200 copay per visit and 20% coinsurance	Covered as In-Network
Emergency Ambulance (Air and Ground)	20% coinsurance after deductible is met	Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Outpatient Mental Health and Substance Use Disorder		
Doctor Office Visit and Online Visit	$20 copay	40% coinsurance after deductible is met
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
Hospital Stay (all inpatient stays including maternity, mental/behavioral health, and substance abuse 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.*	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	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, occupational therapy and speech therapy is limited to 20 visits per benefit period. Applies 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, occupational therapy and speech therapy is limited to 20 visits per benefit period. Applies 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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Cardiac rehabilitation		
Office *Coverage is limited to 36 visits per benefit period. Applies to In-Network Providers and Out-of-Network Providers combined.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital *Coverage is limited to 36 visits per benefit period. Applies to In-Network Providers and Out-of-Network Providers combined.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Skilled Nursing Care (in a facility)	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	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Prosthetic Devices	20% coinsurance after deductible is met	40% 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	Combined with medical out of pocket maximum
Prescription Drug Coverage *Traditional Open Drug List*		
Tier 1 - Typically Lower Cost Generic *Covers up to a 31 day supply (retail pharmacy).*	$10 copay per Prescription	$10 copay per Prescription
Tier 2 – Typically Preferred Brand *Covers up to a 31 day supply (retail pharmacy).*	$30 copay per Prescription	$30 copay per Prescription
Tier 3 - Typically Non-Preferred Brand *Covers up to a 31 day supply (retail pharmacy).*	$60 copay per Prescription	$60 copay per Prescription

Pediatric Vision *Limited to covered persons under the age of 19*.

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 member'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.		
Children's Vision Essential Health Benefits (up to age 19) *Limited to covered persons under the age of 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.*	No charge	$25 Reimbursement for Single, $40 Reimbursement for Bifocal and $55 Reimbursement for Trifocal Vision Lens
Elective contact lenses *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.*	No charge	Reimbursed 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	Reimbursed Up to $210
Adult Vision (age 19 and older)		
Adult Vision Coverage		
Limited to certain vision screenings required by Federal law and covered under the "Preventive Care" benefit.	See "Preventive Care" benefit	See "Preventive Care" benefit

Pediatric Dental *Limited to covered persons under the age of 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.		
Children's Dental Essential Health Benefits (up to age 19) *Limited to covered persons under the age of 19.*		
Diagnostic and preventive *Coverage for In-Network Providers and Out-of-Network Providers combined is limited to 2 visits per benefit period.*	0% coinsurance	0% coinsurance
Basic services	20% coinsurance	20% coinsurance
Major services/Prosthodontics	50% coinsurance	50% coinsurance
Endodontic, Periodontics, Oral Surgery	50% coinsurance	50% coinsurance
Medically Necessary Orthodontia services	50% coinsurance	50% coinsurance
Cosmetic Orthodontia services	Not covered	Not covered
Deductible	None	None

Adult Dental

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Annual Benefit Maximum Contract Year		
Per insured person	$1,500	$1,500
D&P applies to Annual Maximum	Yes	Yes
Annual Maximum Carryover / Carry in	No/No	No/No
Orthodontic Lifetime Benefit Maximum		
Per eligible insured person	N/A	N/A
Annual Deductible Contract Year		
Per insured person/Family maximum	$50/3X Individual	$50/3X Individual
Deductible Waived for Diagnostic/Preventive Services	Yes	Yes
Out-of-Network Reimbursement:	Prime (MAC)	

Covered Dental Benefits	Cost if you use an In-Network-Provider	Cost if you use an Out-of-Network Provider	Waiting Period
Diagnostic and Preventive Services			
Periodic oral exam 2 per 12 months	0% Coinsurance	0% Coinsurance	No Waiting Period
Teeth cleaning (prophylaxis) 2 per 12 months; w/periodontal maintenance	0% Coinsurance	0% Coinsurance	No Waiting Period
Bitewing X-rays: 1 set per 12 months	0% Coinsurance	0% Coinsurance	No Waiting Period
Full-mouth or Panoramic X-rays: 1 per 60 months	0% Coinsurance	0% Coinsurance	No Waiting Period
Fluoride application: 1 per 12 months through age 18	0% Coinsurance	0% Coinsurance	No Waiting Period
Sealants 1 per 60 months; through age 18	0% Coinsurance	0% Coinsurance	No Waiting Period
Basic Services			
Consultation (second opinion) 1 per 12 months	20% Coinsurance	20% Coinsurance	No Waiting Period
Amalgam (silver-colored) Filling 1 per tooth per 24 months	20% Coinsurance	20% Coinsurance	No Waiting Period
Composite (tooth-colored) Filling posterior (back) fillings covered as composites 1 per tooth per 24 months	20% Coinsurance	20% Coinsurance	No Waiting Period
Brush Biopsy (cancer test) Covered, 1 per 12 months; all ages	20% Coinsurance	20% Coinsurance	No Waiting Period
Space Maintainers 1 per lifetime through age 18; posterior teeth	20% Coinsurance	20% Coinsurance	No Waiting Period

Covered Dental Benefits	Cost if you use an In-Network-Provider	Cost if you use an Out-of-Network Provider	Waiting Period
Endodontics (Non-Surgical)			
Root Canal and retreatments 1 per tooth per lifetime	50% Coinsurance	50% Coinsurance	No Waiting Period
Endodontics (Surgical)			
Apicoectomy and apexification 1 per tooth per lifetime	50% Coinsurance	50% Coinsurance	No Waiting Period
Periodontics (Non-Surgical)			
Periodontal Maintenance 2 per 12 months; w/teeth cleaning	20% Coinsurance	20% Coinsurance	No Waiting Period
Scaling and root planing 1 per quadrant per 24 months	20% Coinsurance	20% Coinsurance	No Waiting Period
Periodontics (Surgical)			
Periodontal Surgery (osseous, gingivectomy, graft procedures) 1 per quadrant per 36 months	50% Coinsurance	50% Coinsurance	No Waiting Period
Oral Surgery (Simple)			
Simple Extractions 1 per tooth per lifetime	50% Coinsurance	50% Coinsurance	No Waiting Period
Oral Surgery (Complex)			
Surgical Extractions 1 per tooth per lifetime	50% Coinsurance	50% Coinsurance	No Waiting Period
Major (Restorative) Services			
Crowns, onlays, veneers 1 per tooth per 84 months	50% Coinsurance	50% Coinsurance	No Waiting Period
Cosmetic teeth whitening Not Covered	50% Coinsurance	50% Coinsurance	No Waiting Period
Prosthodontics			
Dentures and bridges 1 per tooth per 84 months	50% Coinsurance	50% Coinsurance	No Waiting Period
Dental Implants Covered, 1 per tooth per 84 month	50% Coinsurance	50% Coinsurance	No Waiting Period
Prosthodontic Repairs/Adjustments			
Crown, denture, bridge repairs 1 per 12 months; 6 months after placement	50% Coinsurance	50% Coinsurance	No Waiting Period
Denture and bridge adjustments: 2 per 12 months; 6 months after placement	50% Coinsurance	50% Coinsurance	No Waiting Period
Orthodontic Services			
None	Not Covered	Not Covered	No Waiting Period

Covered Dental Benefits	Cost if you use an In-Network-Provider	Cost if you use an Out-of-Network Provider	Waiting Period
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
Analgesia, 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**

Designed with you in mind

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.

1. **Acts of War, Disasters, or Nuclear Accidents**
2. **Administrative Charges**
3. **Alternative / Complementary Medicine**
4. **Charges Over the Maximum Allowed Amount**
5. **Cosmetic Services**
6. **Court Ordered Testing**
7. **Custodial Care**
8. **Experimental or Investigational Services**
9. **Eyeglasses and Contact Lenses**
10. **Health Club Memberships and Fitness Services**
11. **Non-Medically Necessary Services**
12. **Nutritional or Dietary Supplements**
13. **Personal Care and Convenience Items**
14. **Private Duty Nursing**
15. **Stand-By Charges**
16. **Travel Costs**
17. **Vision Services**
18. **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:

1. **Clinically-Equivalent Alternatives**
2. **Compound Drugs**
3. **Drugs Prescribed by Providers Lacking Qualifications/ Registrations/Certifications**
4. **Drugs That Do Not Need a Prescription**
5. **Lost or Stolen Drugs**
6. **Non-approved Drugs**
7. **Nutritional or Dietary Supplements**
8. **Off label use**
9. **Over-the-Counter Items**
10. **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 **1-844-412-0752**.

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

ىلع دوجوملا ءاضعلأا تامدخ مقرب لصتا .اًناجم كتغلب ةدعاسملاو تامولعملا هذه ىلع لوصحلا كل قحي
ةقاطب فيرعتلا ةصاخلا كب ةدعاسملل.(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)

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)

Farsi

تروصهب ار اهکمک و تاعلاطا نیا هک دیراد ار قح نیا امش
هب کمک تفایرد یارب .دینک تفایرد ناتدوخ نابز هب ناگیار
جرد ناتییاسانش تراک یور رب هک ءاضعا تامدخ زکرم هرامش
دیریگب سامت ،تسا .(TTY/TDD: 711) هدش

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 ná ahóót'i' t'áá ni nizaad k'ehjí níká a'doowoł t'áá jíík'e. Naaltsoos bee atah nílínígíí bee néého' dólzingo nanitinígíí béésh bee hane' í bikáá' áajį' hodíílnih. (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

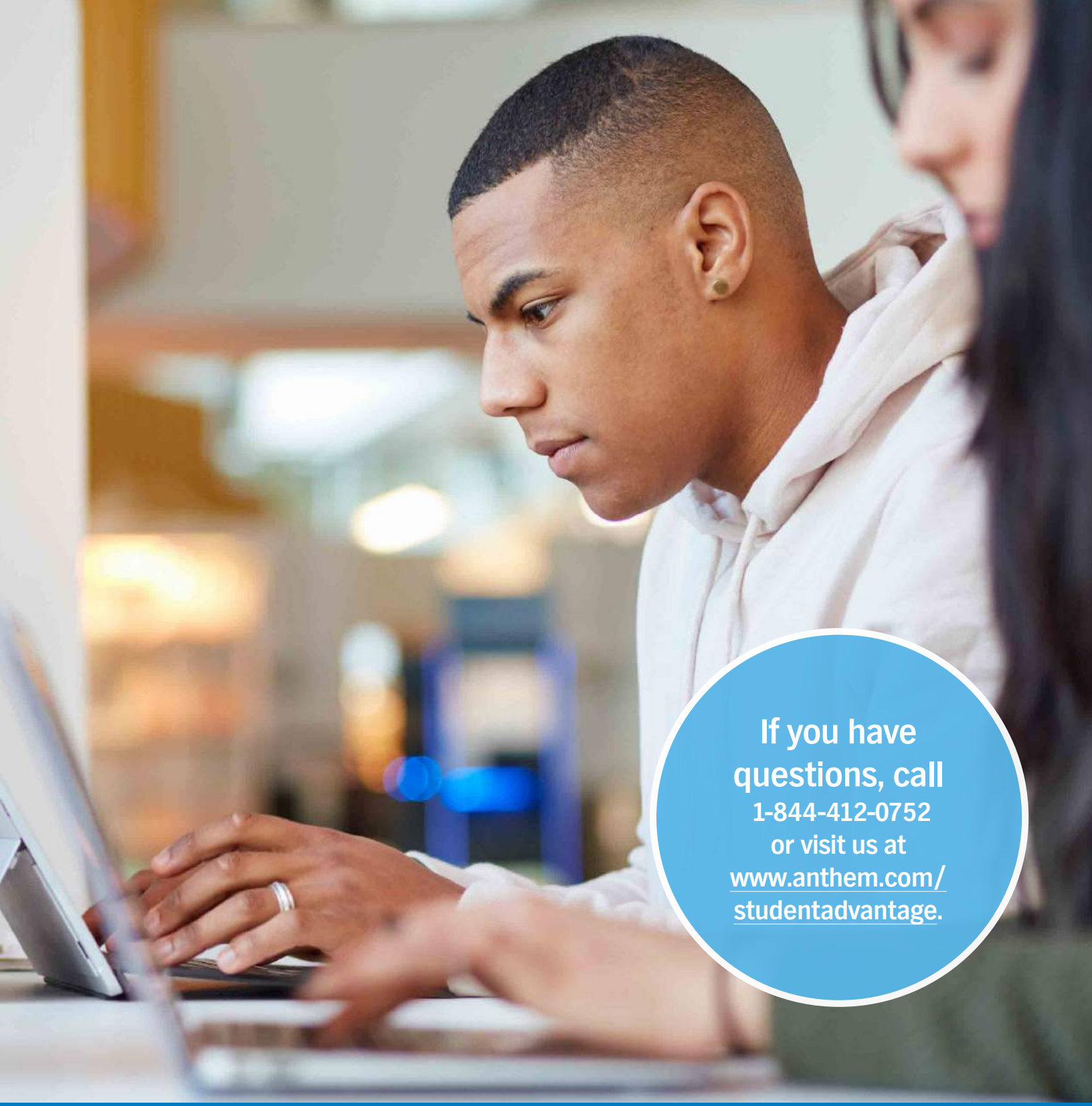
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

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
1-844-412-0752
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