2020-2021

University of Maine System

Student Health Insurance Plan

Undergraduate and Graduate Students

www.anthem.com/studentadvantageca

Anthem Student Advantage

Keeping you at your personal best

A00338MEMENABS 07/20

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 www.anthem.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 full-time undergraduate students taking 9 or more credit hours per semester and full-time graduate students taking 6 or more credit hours per semester are required to have health insurance and are automatically enrolled unless they waive with comparable coverage.
- All domestic undergraduate or domestic graduate students taking less than the required number of credit hours who are enrolled in a program of study that has an insurance requirement.

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

Period	Annual 08/01/2020 – 07/31/2021	Spring 01/01/2021 – 7/31/2021
Student Only	$2,264	$1,314

*The above rates include premiums for the plan, commissions, administrative fees and additional services provided by Gallagher Student Health.
*Rates are pending approval with the state and subject to change.

Important dates for the coverage period

Open enrollment

- Annual:
  06/23/2020 – 10/1/2020
- Spring:
  12/1/2020 – 3/1/2021

Waiver deadlines

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

Annual: 10/1/2020
Spring: 03/1/2021

If you have **questions about enrollment and waiver options,** visit gallagherstudent.com/ums or call 1-833-882-3592.

Keep in touch with your benefits information

Student Health Centers at UMS

University of Maine at Farmington:

Scott Hall, North Entrance
(the right hand side of building as you look from Main Street)

Hours:

The Student Health Center is open when school is in session during the Fall and Spring semesters.

- Monday and Tuesday: 8:30 am – 4:00 pm
- Wednesday 9:30 am – 4:00 pm
- Thursday and Friday: 8:30 am – 4:00 pm

Walk-ins welcome
Administrative staff available Monday – Friday, 8:00am – 8:30am
1-207-778-7200
http://www2.umf.maine.edu/studenthealth/

University of Maine at Presque Isle

Emerson Hall Annex
181 Main St.
Presque Isle, ME 04769
1-207-768-9586
https://www.umpi.edu/offices/health-services/
linda.mastro@maine.edu

Hours:

- Monday through Friday, 1:00 – 5:00 p.m.

The University of Maine at Machias Student Health Center

Sennett Hall
1-207-255-1305
https://machias.edu/campus-life/student-services/health-services/

The University of Maine Orono

Northern Light Primary Care,
Cutler Health Center
5721 Long Road, Orono ME
1-207-581-4000
https://northernlighthealth.org/Locations/Eastern-Maine-Medical-Center/Locations/Primary-Care-UMaine

Hours:

- Monday – Friday
  8:00 am – 5:00 pm,
  closed weekends

University of Southern Maine

Health & Counseling Services
Counseling locations:
105 Payson Smith Hall, Portland;
156 Upton Hall, Gorham;
51 Westminster St, Lewiston
Counseling phone: 1-207-780-4050
Health location: 156 Upton Hall, Gorham
Health phone: 1-207-780-5411
https://usm.maine.edu/uhcs

Claims and coverage

1-844-412-0890
Anthem Blue Cross Life and Health Insurance Company
P.O. Box 105370
Atlanta GA 30348-5370

Benefits, eligibility and enrollment

Gallagher Student Health & Special Risk
1-833-882-3592
gallagherstudent.com/ums
University of Maine System

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 www.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

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

Anthem Student Advantage University of Maine website

Use 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:
University of Maine System

Your network:
Blue Choice 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.

Student Health Center Benefits: The deductible will be waived and benefits will be paid at 100% for Covered Medical Expenses incurred after a $10 Copay per visit when treatment is rendered at the University of Southern Maine and the University of Maine at Farmington Student Health Center. The Deductible will be waived and benefits will be paid at 100% of the approved fee schedule after a $10 Copay per visit when treatment is rendered at the University of Maine Counseling Center. The Deductible will be waived and benefits will be paid at 100% of the approved fee schedule when treatment is rendered at the University of Maine at Presque Isle and The University of Maine at Machias Student Health Center.

Exceptions:

- *Emergency Room or Urgent Care*
- *Services outside the country*
- *Certain women's health services including pregnancy and maternity care*
- *Certain preventative and well visit services*

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.*	$250 per person	$400 per 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. See notes section for additional information regarding your out of pocket maximum.*	$7,900 per person	$15,800 per person
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	20% coinsurance deductible does not apply
Doctor Home and Office Services		
Primary Care Office Visit to treat an injury or illness	$30 copay per visit deductible does not apply	40% coinsurance after deductible is met
Specialist Care Office Visit	$30 copay per visit deductible does not apply	40% coinsurance after deductible is met
Prenatal and Post-natal Care *In-Network preventive prenatal services are covered at 100%.*	Covered at 100% of negotiated charge	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
Other Practitioner Visits:		
Retail Health Clinic	20% coinsurance after deductible is met	40% coinsurance after deductible is met
On-line Medical Visit *Live Health Online is the preferred telehealth solutions (www.livehealthonline.com)*	$30 copay per visit deductible does not apply	40% coinsurance after deductible is met
Chiropractic Services *Coverage is limited to 40 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Acupuncture	Not covered	Not covered
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 Laboratory Facility	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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Emergency and Urgent Care		
Walk In Center (Office Visit Charge)	$30 copay per visit deductible does not apply	40% coinsurance after deductible is met
Emergency Room Facility Services	20% coinsurance after deductible is met, after $200 copay	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after deductible is met	Covered as In-Network
Ambulance Transportation	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse		
Doctor Office Visit and Online Visit	$30 copay per visit deductible does not apply	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)		
Facility fees (for example, room & board) *Coverage for Inpatient rehabilitation and skilled nursing services combined is limited to 150 days per benefit period. Limit is combined In-Network and Non-Network.*	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 Health Care	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
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for physical therapy and occupational therapy combined is limited to 40 visits per benefit period and Speech Therapy is limited to 40 visits per benefit period. Apply to In-Network Providers and Non-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 40 visits per benefit period and Speech Therapy is limited to 40 visits per benefit period. Apply to In-Network Providers and Non-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 40 visits per benefit period and Speech Therapy is limited to 40 visits per benefit period. Apply to In-Network Providers and Non-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 40 visits per benefit period and Speech Therapy is limited to 40 visits per benefit period. Apply to In-Network Providers and Non-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 *Coverage is limited to 40 visits per episode. Limit is combined In-Network and Non-Network across all outpatient settings.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital *Coverage is limited to 40 visits per episode. Limit is combined In-Network and Non-Network across all outpatient settings.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Skilled Nursing Care (in a facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per year. Limit is combined In-Network and Non-Network.*	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 is limited to 1 unit every 36 months per ear through age of 18. Limit is combine In-Network and Non-Network.*	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 *Select 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). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.*	$15 copay per Prescription deductible does not apply (retail only). $37.50 copay per Prescription deductible does not apply (home delivery only).	40% coinsurance
Tier 2 - Typically Preferred Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.*	$45 copay per Prescription deductible does not apply (retail only). $112.50 copay per Prescription deductible does not apply (home delivery only).	40% coinsurance
Tier 3 - Typically Non-Preferred Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.*	$75 copay per Prescription deductible does not apply (retail only). $187.50 copay per Prescription deductible does not apply (home delivery only).	40% coinsurance
Tier 4 - Typically Specialty (brand and generic) *Covers up to a 30 day supply (retail pharmacy). Covers up to a 30 day supply (home delivery program).No coverage for non-formulary drugs.*	$75 copay per Prescription deductible does not apply (retail only). $75 copay per Prescription deductible does not apply (home delivery only).	40% coinsurance

Dental

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		
Diagnostic and preventive *Coverage for In-Network Providers and Non-Network Providers is limited to 2 visits per 12 months.*	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
Medically Necessary Orthodontia services	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Cosmetic Orthodontia services	Not covered	Not covered
Deductible	Combined with medical deductible	Combined with medical deductible
Adult Dental		
Diagnostic and preventive	Not covered	Not covered
Basic services	Not covered	Not covered
Major services	Not covered	Not covered
Deductible	Not covered	Not covered
Annual maximum	Not covered	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 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)		
Child Vision Deductible	$0	$0
Vision exam *Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period.*	No charge	Reimbursed Up to $30
Frames *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $45
Lenses *Coverage for In-Network Providers and Non-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, $70 Reimbursement for Lenticular lenses, $40 Reimbursement for Progressive lenses
Elective contact lenses *Coverage for In-Network Providers and Non-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 Non-Network Providers is limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $210
Adult Vision (age 19 and older)		
Adult Vision Deductible	$0 person	$0 person
Vision exam *Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period.*	$20 copay	Reimbursed Up to $30
Frames	Not covered	Not covered
Lenses	Not covered	Not covered
Elective contact lenses	Not covered	Not covered
Non-Elective Contact Lenses	Not covered	Not covered

Benefits that go with you

You are covered for emergency health situations when travelling abroad. With our 24/7 help center and international network of doctor advisors, you have the right support and services when you need them through GeoBlue®.

In a medical emergency:

1. Go immediately to the nearest doctor or hospital.

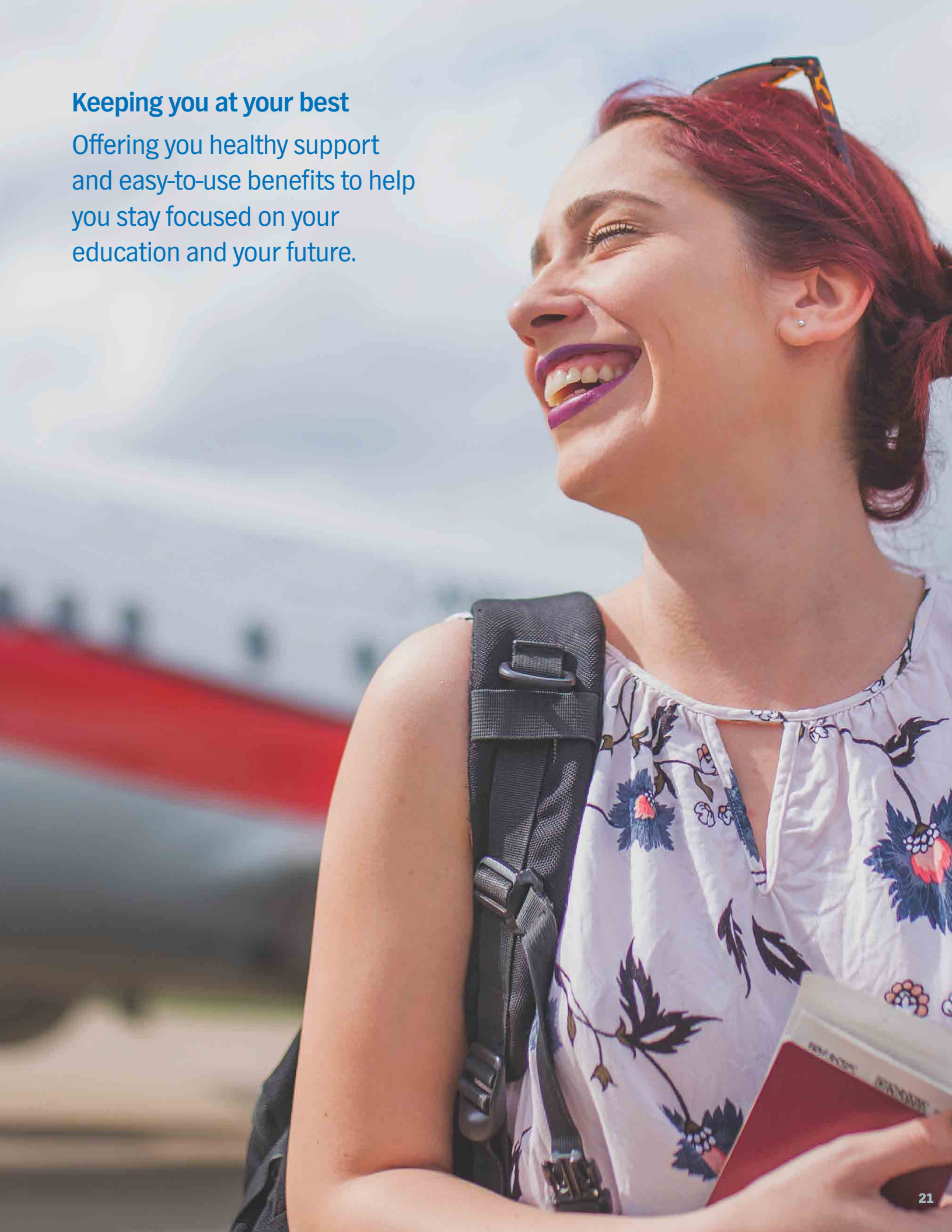
2. Call us at **1-833-511-4763**. The GeoBlue Global Health & Safety Team will contact the doctor treating you and closely monitor your situation to decide whether a medical evacuation is needed. When you call, have this information ready:

   - Your name
   - Details of the emergency
   - The name and contact information of the doctor and/or the hospital treating you
   - The ID number on the front of your member ID card
   - The name of your health coverage program: **Anthem Student Advantage**
   - Your specific location, using GPS if it is available

Your GeoBlue benefits	
Emergency medical evacuation	Unlimited
Repatriation of remains	Unlimited
Emergency family travel arrangements	Maximum benefit up to $5,000 per coverage year
Political emergency and natural disaster evacuation *(Available only when traveling outside the U.S.)*	Covered 100% up to $100,000 per person. Subject to a combined $5,000,000 limit per any one covered event for all people covered under the plan.
Accidental death and dismemberment	Maximum benefit up to $10,000 per coverage year

Use of benefits must be coordinated and approved by GeoBlue.

GeoBlue®



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.

Notes

- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits. Covered out-of-network Human Organ and Tissue Transplant services do not apply toward the out-of-pocket limit.
- The family deductible and out-of-pocket maximum are embedded indicating the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; additionally, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network. If your plan includes out of network benefits and you use a non-participating provider, you are responsible for any difference between the covered expense and the actual non-participating providers charge
- Your coinsurance, copays and deductible count toward your out of pocket amount.
- Human Leukocyte Antigen Testing: Requires 100% coverage (after deductible if CDHP) for up to $150 for both in-network and out-of-network combined. This is a lifetime benefit; no further HLA testing benefits will be available after the $150 benefit has been reached.
- Vision services are not subject to the annual deductible.
- For additional information on this plan, please visit www.sbc.anthem.com to obtain a “Summary of Benefit Coverage.”

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 **1-844-412-0890**.

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 مجاناً. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة (TTY/TDD: 711)

Armenian

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

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

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)

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)

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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.

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