2022-2023

Albert Einstein College of Medicine
Student Health Insurance Plan

www.anthem.com/studentadvantageca

Anthem Student Advantage
Keeping you at your personal best

Empire BlueCross BlueShield | STUDENT ADVANTAGE

An Anthem Company

121363XXMENXXX Rev. 03/23

Important notice

This is a brief description of your student health plan underwritten by Empire Blue Cross and Blue Shield. 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/studentadvantage.

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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 medical students attending the Albert Einstein College of Medicine are required to enroll in the Student Health Insurance Plan at registration, unless proof of comparable coverage is furnished.

To waive online, log onto:
einstein.myahpcare.com/waiver

Coverage is available for dependents too

If you are covered by Anthem Student Advantage through Albert Einstein College of Medicine, you may enroll your lawful spouse, domestic partner or dependent children under the age of 26. Here is how it works:

To enroll eligible dependent(s) of a covered student, please visit **einstein.myahpcare.com/enrollment** during the open enrollment period.

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

Coverage Period	Fall - 2nd - 4th Year 7/1/22 - 12/31/22	Fall - 1st Year 8/15/22 - 12/31/22	Spring/Summer 1/1/23 - 6/30/23
Student	$3,581.09	$2,685.81	$3,581.09
Spouse	$3,581.09	$2,685.81	$3,581.09
One Child	$3,581.09	$2,685.81	$3,581.09

The rates listed above include a prorated annual $2.00 fee for Togetherall behavioral health benefits provided by Togetherall.
*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

- Fall - 2nd - 4th Year: 4/18/22 - 5/13/22
- Fall - 1st Year: 07/15/22 - 8/6/22

Waiver deadlines

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

Fall - 2nd - 4th Year: 5/13/22
Fall - 1st Year: 8/6/22
Spring/Summer: 11/30/22

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

Keep in touch with your benefits information

Claims and coverage

1-844-412-0752
Anthem Blue Cross Life and Health Insurance Company
PO Box 105187 Atlanta, GA 30348-5188

Benefits, eligibility and enrollment

Academic HealthPlans
einstein.myahpcare.com
Albert Einstein College of Medicine

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 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.empireblue.com/find-care/** to find the right doctor or facility close to where you are.

Anthem Student Advantage Albert Einstein College of Medicine 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

Empire Blue Cross and Blue Shield

Student health insurance plan:
Albert Einstein College of Medicine

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	$500 person	$3,500 person
Out-of-Pocket Limit	$5,000 person/$6,600 family	$10,000 person/$30,000 family
The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket maximum; in addition, amounts for all covered family members apply to the family deductible and family out-of-pocket maximum. No one member will pay more than the per person deductible or per person out-of-pocket maximum. *All medical and prescription drugs deductibles, copayments and coinsurance apply toward the out-of-pocket maximum.* *In-network and out-of-network deductibles and out-of-pocket maximum amounts are separate and do not accumulate toward each other.*		
Preventive Care/Screening/Immunization	No charge	30% coinsurance after medical deductible is met
Virtual Care (Telemedicine / Telehealth Visits)		
Virtual Visits with Doctors who also provide services in person Primary Care (PCP)	$20 copay per visit deductible does not apply	30 copay per visit and 30% coinsurance deductible does not apply
Mental Health and Substance Abuse Care	No charge	30% coinsurance deductible does not apply
Specialist Care	$20 copay per visit deductible does not apply	$30 copay per visit and 30% coinsurance deductible does not apply
Virtual Visits from Online Provider LiveHealth Online *via www.livehealthonline.com; our mobile app, website or Anthem-enabled device*		
Primary Care (PCP) and Mental Health and Substance Abuse Care	No charge	30% coinsurance deductible does not apply
Specialist Care	$20 copay per visit deductible does not apply	$30 copay per visit and 30% coinsurance deductible does not apply
Visits in an Office		
Primary Care (PCP)	$20 copay per visit deductible does not apply	$30 copay per visit and 30% coinsurance deductible does not apply
Specialist Care	$20 copay per visit deductible does not apply	$30 copay per visit and 30% coinsurance deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal) *In-Network routine prenatal office visits and other preventive prenatal care and screening are covered at 100%.*	$20 copay per visit deductible does not apply	$30 copay per visit deductible does not apply
Retail Health Clinic	$20 copay per visit deductible does not apply	$30 copay per visit and 30% coinsurance deductible does not apply
Manipulation Therapy	$20 copay per visit deductible does not apply	$30 copay per visit and 30% coinsurance deductible does not apply
Acupuncture	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Other Services in an Office		
Allergy Testing	$20 copay per visit deductible does not apply	$30 copay per visit and 30% coinsurance deductible does not apply
Chemo/Radiation Therapy	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Dialysis/Hemodialysis	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Prescription Drugs - *Dispensed in the office*	$20 copay per visit deductible does not apply	$30 copay per visit deductible does not apply
Surgery	$20 copay per surgery deductible does not apply	$30 copay per surgery and 30% coinsurance deductible does not apply
Diagnostic Services		
Lab		
Office	20% coinsurance deductible does not apply	40% coinsurance deductible does not apply
Freestanding Lab/Reference Lab	20% coinsurance deductible does not apply	40% coinsurance deductible does not apply
Outpatient Hospital	20% coinsurance deductible does not apply	40% coinsurance deductible does not apply
X-Ray		
Office	20% coinsurance deductible does not apply	40% coinsurance deductible does not apply
Freestanding Radiology Center	20% coinsurance deductible does not apply	40% coinsurance deductible does not apply
Outpatient Hospital	20% coinsurance deductible does not apply	40% coinsurance deductible does not apply
Advanced Diagnostic Imaging		
Office	20% coinsurance deductible does not apply	40% coinsurance deductible does not apply
Freestanding Radiology Center	20% coinsurance deductible does not apply	40% coinsurance deductible does not apply
Outpatient Hospital	20% coinsurance deductible does not apply	40% coinsurance deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Emergency and Urgent Care		
Urgent Care	$20 copay per visit deductible does not apply	$40 copay per visit and 30% coinsurance deductible does not apply
Emergency Room Facility Services	$150 copay per visit and 20% coinsurance deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	No charge	Covered as In-Network
Emergency Ambulance	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	No charge	30% coinsurance deductible does not apply
Facility Visit: *Coinsurance limited to the copay amount reflected for Primary Care Office visit.* Facility Fees	No charge	30% coinsurance deductible does not apply
Doctor Services	No charge	30% coinsurance deductible does not apply
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 (Including Maternity, Mental / Behavioral Health, Substance Abuse)		
Facility fees *Coverage for Inpatient Rehabilitation is limited to 60 days per benefit period.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Human Organ and Tissue Transplants *Coverage includes acquisition and transplant procedures, collection and storage.*	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
Rehabilitation services		
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
Habilitation services		
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
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
Skilled Nursing Care (facility)	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Inpatient 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 Limit	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
Prescription Drug Coverage *Cost shares for drugs included on the Traditional Open drug list appear below. Your plan uses the . You may receive up to a 90 day supply of medication at Retail 90 pharmacies.*		
Home Delivery Pharmacy *You will need to call us on the number on your ID card to sign up when you first use the service.*		
Tier 1 - Typically Generic *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	Tier 1 - $20 copay per prescription, deductible does not apply (retail) and $50 copay per prescription, deductible does not apply (home delivery)	Tier 1 - $20 copay per prescription, deductible does not apply (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	Tier 2 - $40 copay per prescription, deductible does not apply (retail) and $100 copay per prescription, deductible does not apply (home delivery)	Tier 2 - $40 copay per prescription, deductible does not apply (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand / Specialty Drugs *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery). Per 30 day (specialty pharmacy).*	Tier 3 - $60 copay per prescription, deductible does not apply (retail) and $150 copay per prescription, deductible does not apply (home delivery)	Tier 3 - $60 copay per prescription, deductible does not apply (retail) and Not covered (home delivery)

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. Only children's vision services count towards your out of pocket limit.		
Children's Vision Essential Health Benefits (up to age 19)		
Vision exam *Limited to 1 exam per benefit period.*	No charge	Reimbursed Up to $30
Frames *Limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $45
Lenses *Limited to 1 unit per benefit period combined with OON Coverage. OON Reimbursement: Single Reimbursed Up to $25, Bifocal Reimbursed Up to $40, Trifocal Reimbursed Up to $55.*	No charge	Receives Reimbursement
Elective Contact Lenses *Limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $60
Non-Elective Contact Lenses *Limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $210

Adult Vision

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Adult Vision Coverage		
Exam Copay and Frequency	$10 Once Every Benefit Period	Reimbursed Up to $42
Prescription Lens Copay and Frequency *Limited to 1 unit per benefit period combined with OON Coverage. OON Reimbursement: Single Reimbursed Up to $40, Bifocal Reimbursed Up to $60, Trifocal Reimbursed Up to $80.*	$10 Once Every Benefit Period	Receives Reimbursement
Frame Benefit and Frequency	$130 Once Every 2 Benefit Periods	Reimbursed Up to $45
Elective Contact Lens Benefit and Frequency	$130 Once Every Benefit Period	Reimbursed Up to $105
Non Elective Contact Lens Benefit and Frequency	Covered in Full Once Every Benefit Period	Reimbursed $210

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. Only children's dental services count towards your out of pocket limit.		
Children's Dental Essential Health Benefits (up to age 19)		
Diagnostic and preventive *Limited to 2 visits per 12 months.*	No charge	No charge
Basic services	20% coinsurance deductible does not apply	20% coinsurance deductible does not apply
Major services	50% coinsurance deductible does not apply	50% coinsurance deductible does not apply
Medically Necessary Orthodontia services	50% coinsurance deductible does not apply	50% coinsurance deductible does not apply
Cosmetic Orthodontia services	Not covered	Not covered
Deductible	Combined with medical deductible	Combined with medical deductible

Adult Dental

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Deductibles		
Annual Deductible	$50	$50
Family Deductible	3X Individual	3X Individual
Deductible Waived - Diag/Prev	Yes	Yes
Deductible Waived – Orthodontics	N/A	N/A
Cost-Shares		
Diagnostic & Preventive	100% Coinsurance	100% Coinsurance
Basic Restorative	80% Coinsurance	80% Coinsurance
Non Surgical Endodontics	Not Covered	Not Covered
Surgical Endodontics	Not Covered	Not Covered
Non Surgical Periodontics	80% Coinsurance	80% Coinsurance
Surgical Periodontics	50% Coinsurance	50% Coinsurance
Simple Oral Surgery	50% Coinsurance	50% Coinsurance
Complex Oral Surgery	50% Coinsurance	50% Coinsurance
Major Restorative	Not Covered	Not Covered
Prosthetics	Not Covered	Not Covered
Prosthetic Repairs & Adjustments	Not Covered	Not Covered
Orthodontics	Not Covered	Not Covered
Orthodontic Covers	None	None
Maximums		
Annual Maximum	$1,000	$1,000
Annual Maximum Carryover/Carry in	No/No	No/No
Out of Pocket Maximum Individual/Family	Not Applicable	Not Applicable
Lifetime Orthodontic Maximum	N/A	N/A

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.

Notes

- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- When using a non-network pharmacy, members are responsible for the stated copay & costs in excess of the prescription drug maximum allowed amount. Members will pay upfront and submit a claim form.
- For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to https://le.anthem.com/pdf?x=NY_SH_PPOL04962.

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.

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 .ًأناجم كتغلب ةدعاسملاو تامولعملا هذه ىلع لوصحلا كل قحي
(TTY/TDD: 711).ةدعاسملا كب ةصاخلا فيرعتلا ةقاطب

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

تروصب هب 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

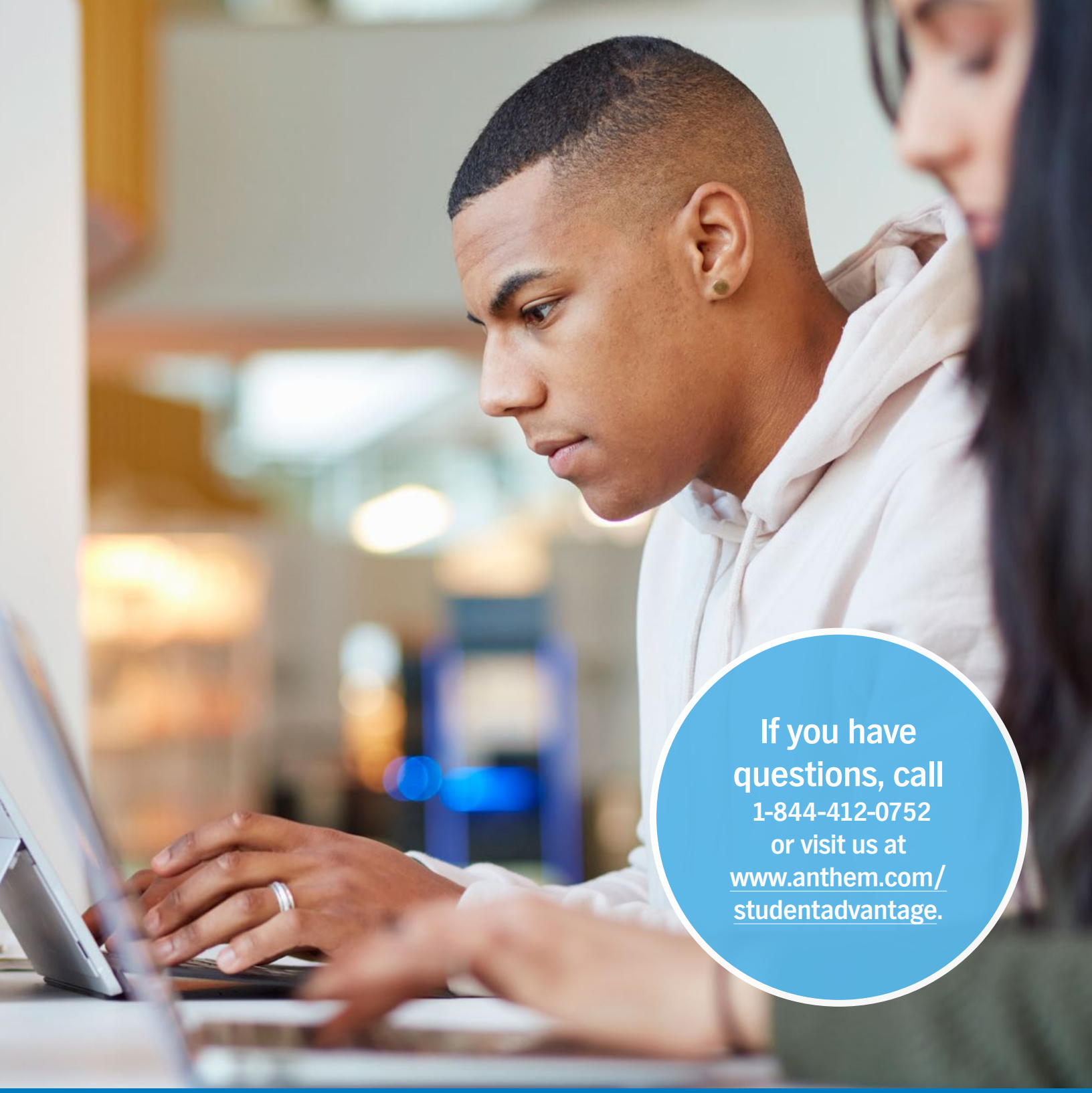
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

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.



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