

2020-2021



St. John's University Student Health Insurance Plan

empireblue.com/studentadvantage

Anthem Student Advantage

Keeping you at your personal best

Empire   | STUDENT ADVANTAGE
BLUECROSS BLUESHIELD

125668NYMENESA 11/20

An Anthem Company



Important notice

This is a brief description of your student health plan underwritten by Empire BlueCross BlueShield (Empire). 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 empireblue.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 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 registered undergraduate and graduate students are eligible to enroll in the Student Health Insurance Plan.
- › Registered non-resident undergraduate and graduate students are eligible to enroll on a voluntary basis.
- › All eligible resident students are automatically enrolled in the plan unless they can provide evidence of equivalent coverage satisfactory to St. John's University.
- › Enrollment is mandatory for all international students with a current passport and student Visa (J-1 or F-1) who are temporarily located outside their home country and are actively engaged in education or educational research activities at St. John's University.

All international students are automatically enrolled in the University's Student Health Insurance Plan, and may not waive out of it.

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

	Annual	New Spring
Coverage dates	8/15/2020 - 8/14/2021	1/1/2021-8/14/2021
Premium	\$2,375	\$1,483

*The rates listed above include an annual \$10.08 fee for GeoBlue Medical Evacuation and Repatriation Benefit provided by 4 Ever Life International Limited and an administrative fee of \$32 charged by the school through which you receive coverage.





Important dates for the coverage period



Open enrollment and waiver deadlines

- › Students beginning fall semester: September 7, 2020
- › Students beginning spring semester: February 8, 2021

If you have questions about enrollment and waiver options, contact University Health Plans at **800-437-6448** or info@univhealthplans.com.

Keep in touch with your benefits information



Student Health Center

Refer to the student health center website for location, hours, and services:

www.stjohns.edu/life-st-johns/health-and-wellness/student-health-services



Benefits, claims, and coverage

844-412-0752

Empire Blue Cross Blue Shield

Download the Sydney Health app on Google Play or the App Store to access claims and coverage information.



Eligibility and enrollment

St. John's University has partnered with University Health Plans to administer the plan and help with waiver, enrollment, or benefit-related questions. University Health Plans can be reached at **800-437-6448** or info@univhealthplans.com.

Easy access to care

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



Sydney Health app

With the Sydney Health¹ 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 StoreSM or Google PlayTM and search for the Sydney Health app to download it today.



Provider finder

Use <https://www.empireblue.com/find-care/> to find the right doctor or facility close to where you are.



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 **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.

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 BlueCross
BlueShield

Student health insurance plan:

St. John's University

Your network:

Empire Blue Access PPO

Medical

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.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<p>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.</p>	\$50 student	\$50 student
<p>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.</p>	\$3,500 student	\$7,000 student
<p>Preventive care/screening/immunization In-network preventive care is not subject to deductible, if your plan has a deductible.</p>	No charge	0% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit to treat an injury or illness	5% coinsurance, after deductible is met	20% coinsurance after deductible is met
Specialist Care Visit	5% coinsurance, after deductible is met	20% coinsurance after deductible is met
<p>Prenatal Care In-Network preventive prenatal services are covered at 100%.</p>	No charge	20% coinsurance after deductible is met
Post-natal Care	5% coinsurance after deductible is met	20% 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	5% coinsurance after deductible is met	20% coinsurance after deductible is met
Chiropractic	5% coinsurance after deductible is met	20% coinsurance after deductible is met
Acupuncture 10 visit limit	5% coinsurance after deductible is met	20% coinsurance after deductible is met
Other Services in an Office:		
Allergy Testing Performed by a Primary Care Physician	5% coinsurance after deductible is met	20% coinsurance after deductible is met
Allergy Testing Performed by a Specialist	5% coinsurance after deductible is met	20% coinsurance after deductible is met
Chemo/Radiation Therapy Performed by a Primary Care Physician	5% coinsurance after deductible is met	20% coinsurance after deductible is met
Chemo/Radiation Therapy Performed by a Specialist	5% coinsurance after deductible is met	20% coinsurance after deductible is met
Hemodialysis Performed by a Primary Care Physician	5% coinsurance after deductible is met	20% coinsurance after deductible is met
Hemodialysis Performed by a Specialist	5% coinsurance after deductible is met	20% coinsurance after deductible is met
Hemodialysis Performed as Outpatient Hospital Services	5% coinsurance after deductible is met	20% coinsurance after deductible is met
Prescription Drugs Administered in an Office by a Primary Care Physician For the drugs itself dispensed in the office through infusion/injection.	5% coinsurance after deductible is met	20% coinsurance after deductible is met
Prescription Drugs Administered in an Office by a Specialist For the drugs itself dispensed in the office through infusion/injection.	5% coinsurance after deductible is met	20% 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
Diagnostic Services Lab:		
Office Performed by a Primary Care Physician	5% coinsurance after deductible is met	20% coinsurance after deductible is met
Office Performed by a Specialist	5% coinsurance after deductible is met	20% coinsurance after deductible is met
Freestanding Lab/Reference Lab <i>Empire's participating Freestanding Labs are Laboratory Corporation of America or Quest Diagnostics. Please check Provider Finder for additional participating Freestanding Labs in your area.</i>	5% coinsurance after deductible is met	20% coinsurance after deductible is met
Outpatient Hospital	5% coinsurance after deductible is met	20% coinsurance after deductible is met
X-Ray:		
Office Performed by a Primary Care Physician	5% coinsurance after deductible is met	20% coinsurance after deductible is met
Office Performed by a Specialist	5% coinsurance after deductible is met	20% coinsurance after deductible is met
Outpatient Hospital	5% coinsurance after deductible is met	20% coinsurance after deductible is met
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):		
Office	5% coinsurance after deductible is met	20% coinsurance after deductible is met
Outpatient Hospital	5% coinsurance after deductible is met	20% coinsurance after deductible is met
Emergency and Urgent Care (Office setting)	5% coinsurance after deductible is met	20% coinsurance after deductible is met
Emergency Room Facility Services Copay waived if admitted.	5% coinsurance after deductible is met	20% coinsurance after deductible is met
Emergency Room Doctor and other services	5% coinsurance	20% coinsurance after deductible is met
Ambulance (air and ground)	5% coinsurance after deductible is met	20% 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
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	5% coinsurance after deductible is met	20% coinsurance after deductible is met
Facility visit:		
Facility Fees	5% coinsurance after deductible is met	20% coinsurance after deductible is met
Doctor Services	5% coinsurance after deductible is met	20% coinsurance after deductible is met
Outpatient Surgery Facility Fees		
Hospital	5% coinsurance after deductible is met	20% coinsurance after deductible is met
Freestanding Surgical Center	5% coinsurance after deductible is met	20% coinsurance after deductible is met
Doctor and Other Services:		
Surgery Performed by a Primary Care Physician	5% coinsurance after deductible is met	20% coinsurance after deductible is met
Surgery Performed by a Specialist	5% coinsurance after deductible is met	20% coinsurance after deductible is met
Freestanding Surgical Center	5% coinsurance after deductible is met	20% coinsurance after deductible is met
Hospital Stay (all inpatient stays including Maternity, Mental/Behavioral Health, and Substance Abuse)		
Facility fees (for example, room & board) <i>Coverage for Inpatient Rehabilitation is limited to 30 days per year. Limit is combined In-Network and Out-of-Network.</i>	5% coinsurance after deductible is met	20% coinsurance after deductible is met
Doctor and other services	5% coinsurance after deductible is met	20% coinsurance after deductible is met
Recovery & Rehabilitation Home Health Care <i>Coverage is limited to 40 visits per year. Limit is combined In-Network and Out-of-Network.</i>	5% coinsurance after deductible is met	5% 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 rehabilitative and habilitative physical therapy, occupational therapy and speech therapy combined is limited to 60 visits per year. Applies to In-Network and Out-of-Network. Limit is combined across professional visits and outpatient facilities.	5% coinsurance after deductible is met	5% coinsurance after deductible is met
Outpatient Hospital Coverage for rehabilitative and habilitative physical therapy, occupational therapy, and speech therapy combined is limited to 60 visits per year. Applies to In-Network and Out-of-Network. Limit is combined across professional visits and outpatient facilities.	5% coinsurance after deductible is met	5% coinsurance after deductible is met
Habilitation services (for example, physical/speech/occupational therapy):		
Office Coverage for rehabilitative and habilitative physical therapy, occupational therapy, and speech therapy combined is limited to 60 visits per year. Applies to In-Network and Out-of-Network. Limit is combined across professional visits and outpatient facilities.	5% coinsurance after deductible is met	5% coinsurance after deductible is met
Outpatient Hospital Coverage for rehabilitative and habilitative physical therapy, occupational therapy, and speech therapy combined is limited to 60 visits per year. Applies to In-Network and Out-of-Network. Limit is combined across professional visits and outpatient facilities.	5% coinsurance after deductible is met	5% coinsurance after deductible is met
Cardiac rehabilitation		
Office	5% coinsurance after deductible is met	20% coinsurance after deductible is met
Outpatient Hospital	5% coinsurance after deductible is met	20% coinsurance after deductible is met
Hospice	5% coinsurance after deductible is met	20% coinsurance after deductible is met
Durable Medical Equipment	5% coinsurance after deductible is met	20% coinsurance after deductible is met
Prosthetic Devices	5% coinsurance after deductible is met	20% coinsurance after deductible is met

Pharmacy

Covered Pharmacy 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
<p>Prescription drug coverage <i>Traditional Open Drug List</i> This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies.</p>		
<p>Tier 1 - Typically generic <i>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.</i></p>	\$15 copay per prescription (retail) and \$45 copay per prescription (home delivery)	\$15 copay per prescription (retail) and not covered (home delivery)
<p>Tier 2 – Typically preferred brand <i>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.</i></p>	\$30 copay per prescription (retail) and \$75 copay per prescription (home delivery)	\$30 copay per prescription (retail) and not covered (home delivery)
<p>Tier 3 - Typically non-preferred brand/specialty drugs <i>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.</i></p>	\$45 copay per prescription (retail) and \$112.50 copay per prescription (home delivery)	Not covered

Vision

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Children's Vision Essential Health Benefits (up to age 19)		
Child Vision Deductible	\$0 student	\$0 student
Vision exam <i>Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 exam per benefit period.</i>	No charge	Reimbursed Up to \$30
Frames <i>Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.</i>	No charge	Reimbursed Up to \$45
Lenses <i>Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.</i>	No charge	\$25 Reimbursement for Single, \$45 Reimbursement for Bifocal, \$55 Reimbursement for Trifocal Vision Lens and \$70 for Lenticular lens
Elective contact lenses <i>Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.</i>	No charge	Reimbursed Up to \$60
Non-elective contact lenses <i>Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.</i>	No charge	Reimbursed Up to \$210
Adult vision (age 19 and older)		
Adult Vision Coverage <i>Limited to certain vision screenings required by Federal law and covered under the "Preventive Care" benefit.</i>	Not covered	Not covered



Dental

Covered Dental Benefits (up to age 19)	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Children's dental essential health Benefits diagnostic and preventive <i>Includes cleanings, exams, x-rays, sealants, fluoride</i>	No charge	No charge
Basic services <i>Includes fillings and simple extractions</i>	No charge	No charge
Major services/Prosthodontic	50% coinsurance	50% coinsurance
Endodontic, Periodontics, Oral Surgery	50% coinsurance	50% coinsurance
Medically Necessary Orthodontia	50% coinsurance	50% coinsurance
Deductible	Not applicable	Not applicable
Adult Dental	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 **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 <i>(Available only when traveling outside the U.S.)</i>	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.



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

No coverage is available under this certificate for the following:

A. Aviation

We do not cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

B. Convalescent and custodial care

We do not cover services related to rest cures, custodial care, or transportation. "Custodial care" means help in transferring, eating, dressing, bathing, toileting, and other such related activities. Custodial care does not include covered services determined to be medically necessary.

C. Conversion therapy

We do not cover conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a member under 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for any individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support, and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

D. Cosmetic services

We do not cover cosmetic services, prescription drugs, or surgery, unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered child which has resulted in a functional defect. We also cover services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this certificate. Cosmetic surgery does not include surgery determined to be medically necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the utilization review process in the utilization review and external appeal sections of this certificate unless medical information is submitted.

E. Coverage outside of the United States, Canada or Mexico

We do not cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for emergency services, pre-hospital emergency medical services and ambulance services to treat your emergency condition.

F. Dental services

We do not cover dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or dental care or treatment specifically stated in the Outpatient and Professional services and Pediatric Dental Care sections of this certificate.

G. Experimental or investigational treatment

We do not cover any health care service, procedure, treatment, device or Prescription Drug that is experimental or investigational. However, we will cover experimental or investigational treatments, including treatment for your rare disease or patient costs for your participation in a clinical trial as described in the Outpatient and Professional Services section of this certificate, when our denial of services is overturned by an external appeal agent certified by the state. However, for clinical trials, we will not cover the costs of any investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be covered under this certificate for non-investigational treatments. See the utilization review and external appeal sections of this certificate for a further explanation of your appeal rights.

H. Felony participation

We do not cover any illness, treatment, or medical condition due to your participation in a felony, riot or insurrection. This exclusion does not apply to coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of your medical condition (including both physical and mental health conditions).

I. Foot care

We do not cover routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet. However, we will cover foot care when you have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in your legs or feet.

J. Government facility

We do not cover care or treatment provided in a hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law unless you are taken to the hospital because it is close to the place where you were injured or became ill, and emergency services are provided to treat your emergency condition.

K. Medically necessary

In general, we will not cover any health care service, procedure, treatment, test, device, or prescription drug that we determine is not medically necessary. If an external appeal agent certified by the state overturns our denial, however, we will cover the service, procedure, treatment, test, device, or prescription drug for which coverage has been denied, to the extent that such service, procedure, treatment, test, device, or prescription drug is otherwise covered under the terms of this certificate.

L. Medicare or other governmental program

We do not cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

M. Military service

We do not cover an illness, treatment, or medical condition due to service in the Armed Forces or auxiliary units.

N. No-fault automobile insurance

We do not cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if you do not make a proper or timely claim for the benefits available to you under a mandatory no-fault policy.

O. Services not listed

We do not cover services that are not listed in this certificate as being covered.

P. Services provided by a family member

We do not cover services performed by a member of the covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister, or brother of you or your spouse.

Q. Services separately billed by hospital employees

We do not cover services rendered and separately billed by employees of hospitals, laboratories, or other institutions.

R. Services with no charge

We do not cover services for which no charge is normally made.

S. Vision services

We do not cover the examination or fitting of eyeglasses or contact lenses, except as specifically stated in the pediatric vision care section of this certificate.

T. War

We do not cover an illness, treatment, or medical condition due to war, declared, or undeclared.

U. Workers' compensation

We do not cover services if benefits for such services are provided under any state or federal workers' compensation, employers' liability, or occupational disease law.

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 **1-855-330-1098**.

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

تامدخ مقرب لصرتا. إن اجم كنت غلب تدع اسجل او تامول عملًا ذه ولدع لوصول لكل قوجي تدع اسجل لكب فصائلنا (TTY/TDD: 711) فديرع شلا تقاطب ولدع دوجولنا ءاضعال

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 ਮੁਫਤ 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>.



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