This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **hr2.chevron.com/retiree,** or by calling the Chevron Human Resources Service Center at 1-888-825-5247 (or 610-669-8595 if outside the U.S.).

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For Network Providers. **$1,000** You Only **$2,000** You and One Adult/**$1,000** Per Person **$2,000** You and Child(ren)/**$1,000** Per Person **$3,000** You and Family/**$1,000** Per Person For Out-of-Network Providers. **$2,000** You Only **$4,000** You and One Adult/**$2,000** Per Person **$4,000** You and Child(ren)/**$2,000** Per Person **$6,000** You and Family/**$2,000** Per Person Deductible does not apply to certain preventive care in network as specified by the Affordable Care Act. Prescription drugs are subject to a separate deductible. The following are a few major exceptions that do not count toward the deductible: your share of costs and expenses under the Prescription Drug Program, Vision Program, and Mental Health and Substance Abuse Plan; charges that aren't covered or medically necessary under the plan; charges in excess of contracted fees/allowable charges by an out-of-network provider (balanced billed charges), and health care this plan doesn't cover.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 4 for how much you pay for covered services after you meet the **deductible**.

Are there other deductibles for specific services?	Yes. Prescription Drugs **$400** You Only (Retail) **$800** You and Family/**$400** Per Person (Retail) The deductible does not apply to certain preventive prescription drugs as required by the Affordable Care Act and mail-order. Medical services are subject to a separate deductible. The following are a few major exceptions that do not count toward the Prescription Drugs deductible: the amounts you pay through mail order pharmacy, difference between cost of generic and brand-name drug, the difference between the network and the out-of-network pharmacy price (including when you don't provide your ID card at a network pharmacy) and charges that aren't covered by the Prescription Drug Program. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.

Important Questions	Answers	Why this Matters:
Is there an out–of–pocket limit on my expenses?	Yes. For Medical and Mental Health and Substance Abuse combined: For Network Providers **$5,000** You Only **$10,000** You and One Adult/**$5,000** Per Person **$10,000** You and Child(ren) /**$5,000** Per Person **$10,000** You and Family/**$5,000** Per Person	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.

	For Out-of-Network providers **$10,000** You Only **$20,000** You and One Adult/**$10,000** Per Person **$20,000** You and Child(ren) /**$10,000** Per Person **$20,000** You and Family/**$10,000** Per Person For Prescription Drugs: **$1,800** You Only **$3,600** You and Family/**$1,800** Per Person	
What is not included in the out–of–pocket limit?	The following are a few major exceptions that do not count toward the medical out-of-pocket limit: premiums; your share of costs and expenses under the Prescription Drug Program and the Vision Program; charges that aren't deemed medically necessary under the plan; penalties for failure to obtain pre-authorization for services; charges in excess of contracted fees/allowable charges by an out-of-network provider (balanced billed charges) and health care this plan doesn't cover. The following are major exceptions that do not count toward the prescription drug out-of-pocket limits: premiums; difference between the cost of generic and brand name drugs; additional coinsurance amount when you go to a retail network pharmacy after the first refill of a prescription for maintenance medications; charges that aren't covered under the Prescription Drug Program.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.

Important Questions	Answers	Why this Matters:
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 4 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of medical **network providers**, see www.anthem.com/ca or call 1-844-627-1632. For a list of prescription drug **network providers**, see Express-Scripts.com or call 1-800-987-8368. (Plan Group Number is CT1839.)	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 4 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 8. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit	40% after deductible	If you receive services in addition to an office visit, additional copays, deductibles, or coinsurance may apply.
	Specialist visit	$40 copay/visit	40% after deductible	
	Other practitioner office visit	Chiropractor: $40 copay/office visit; 20% (no deductible) for treatment at outpatient facility.	40% after deductible	Chiropractic – limited to 20 visits per calendar year whether provider is in or out-of-network.
	Preventive care/screening/immunization	No charge for certain preventive care as specified by the Affordable Care Act.	40% after deductible	Immunizations for travel are not covered.
If you have a test	Diagnostic test (x-ray, blood work)	20% after deductible	40% after deductible	Labs related to maternity covered at 100% in-network only.
	Imaging (CT/PET scans, MRIs)	20% after deductible	40% after deductible	None

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at express-scripts.com.	Generic drugs	**Retail:** $5 copay after deductible. **Mail Order:** $15 copay with no deductible.	**Retail** The same as network coverage plus difference between the network and out-of-network cost of drug. **Mail order** Not covered.	• Certain items identified by your plan as preventative care are covered in full and not subject to the copay or deductible amounts indicated. Coverage for these drugs is the same if you use an out-of-network retail provider, however, you will pay the difference between the network price and the out-of-network price of the drug. • Covers up to 30 day supply (retail prescription); 90 supply (mail-order prescription). • Your plan uses a preferred drug list, also referred to as a formulary, which identifies the status of covered drugs. • Some drugs may require pre-authorization. If the necessary preauthorization is not obtained, the drug may not be covered. • Your plan uses utilization management programs that require you try one or more drugs before another drug will be covered. • Your plan may limit the quantity of a covered drug. • You pay the difference in cost if you request a brand name drug instead of its generic equivalent. • After a prescription for a non-specialty drug is filled 2 times at retail, a 60% retail coinsurance and applicable minimum copay apply. The coinsurance and copay do not count toward the out-of-pocket maximum. • Refills for Specialty Maintenance Drugs only available through mail-order.
	Preferred brand drugs	**Retail:** 20% after deductible with $15 minimum copay. **Mail Order:** 15% with $35 minimum copay with no deductible.		
	Non-preferred brand drugs	**Retail:** 30% after deductible with $30 minimum copay. **Mail Order:** 25% with $75 minimum copay with no deductible.		
	Specialty drugs	See Generic, Preferred brand, and Non-preferred brand drugs above for cost information.	Same as network coverage plus difference between network and out-of-network price of drug. Mail order not covered.	

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% after deductible	40% after deductible	None
	Physician/surgeon fees	20% after deductible	40% after deductible	None
If you need immediate medical attention	Emergency room services	$250 copay	$250 copay	None
	Emergency medical transportation	20% after deductible	20% after deductible	None
	Urgent care	20% after deductible	40% after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% after deductible	40% after deductible	Pre-notification is required
	Physician/surgeon fee	20% after deductible	40% after deductible	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Not covered	Not covered	Benefits may be provided by the Mental Health and Substance Abuse Plan. For more information, go to hr2.chevron.com, or call 1-888-825-5247 (or 610-669-8595 if outside the U.S.) for information.
	Mental/Behavioral health inpatient services	Not covered	Not covered	
	Substance use disorder outpatient services	Not covered	Not covered	
	Substance use disorder inpatient services	Not covered	Not covered	
If you are pregnant	Prenatal and postnatal care	No charge	40% after deductible	Labs related to maternity covered at 100%
	Delivery and all inpatient services	20% after deductible	40% after deductible	The healthy baby is not subject to his or her own deductible while initially in the hospital after delivery.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20%, no deductible	40% of allowable charges, no deductible.	Pre-notification required; limited to 60 visits per year, combined network and out-of-network.
	Rehabilitation services	20% for treatment at outpatient facility, no deductible	40% of allowable charges after deductible	90 visits combined maximum for physical, occupational and speech therapies per calendar year.
	Habilitation services	Not covered	Not covered	No coverage for Habilitation services.
	Skilled nursing care	20% after deductible	40% after deductible	Pre-notification required; limited to 120 days per calendar year.
	Durable medical equipment	20% of contracted fees after deductible	40% of allowable charges after deductible	Pre-notification required for any item with a purchase price or cumulative rental price above $1000.
	Hospice service	20% of contracted fees, no deductible	40% of allowable charges, no deductible.	Pre-notification required.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Benefits may be provided by the Chevron Corporation Vision Program. For more information, go to hr2.chevron.com, or call 1-888-825-5247 (or 610-669-8595 if outside the U.S.) for information.
	Glasses	Not covered	Not covered	
	Dental check-up	Not covered	Not covered	No coverage for dental check-up under this plan.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery.
- Dental care (Adult and Child).
- Glasses (Adult and Child).
- Habilitation services.
- Hearing Aids (for children over age 26) and adults.
- Long-term care.
- Mental health, behavioral health and substance abuse.
- Routine foot care.
- Weight loss programs.
- Routine eye care (Adult and Child).

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture.
- Bariatric surgery.
- Chiropractic care.
- Hearing Aids (children up through age 26).
- Infertility treatment.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-825-5247 (inside the U.S.) or 610-669-8595 (outside the U.S.). You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Chevron Human Resources Service Center at 1-888-825-5247 (or 610-669-8595 if outside the U.S.); or hr2.chevron.com; or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272); or www.dol.gov/ebsa/healthreform.

For grievance and appeals regarding your medical coverage, call Anthem Blue Cross Member Services at 1-844-627-1632 or visit www.anthem.com/ca. For grievance and appeals regarding your prescription drug coverage, call Express Scripts Member Services at 1-800-987-8368 or visit www.express-scripts.com.

Additionally, a consumer assistance program can help you file your appeal. You may also contact the Chevron Human Resources Service Center at 1-888-825-5247 (or 610-669-8595 if outside the U.S.) for help finding this information.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-825-5247.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-825-5247.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-888-825-5247.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-825-5247.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,120
- **Patient pays** $2,420

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,020
Copays	$0
Coinsurance	$1,250
Limits or exclusions	$150
Total	**$2,420**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,660
- **Patient pays** $1,740

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,150
Copays	$320
Coinsurance	$190
Limits or exclusions	$80
Total	**$1,740**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Language Access Services:

(TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (xxx) xxx-xxxx

Amharic (አማርኛ)፦ ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (xxx) xxx-xxxx ይደውሉ።

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (xxx) xxx-xxxx.

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (xxx) xxx-xxxx:

Bassa (Bǎsɔ̀ɔ̀ Wùdù): M̀ dyi dyi-diè-dɛ̀ bě bédé bá céè-dɛ̀ nìà kɛ dyí ní, ɔ mɔ̀ nì dyí-bɛ̀dɛ̀ìn-dɛ̀ bɛ́ m̀ ké gbo-kpá-kpá kè bɔ̌ kpɔ̃ dé m̀ bídí-wùdùǔn bó pídyi. Bɛ́ m̀ ké wudu-zììn-nyɔ̀ dò gbo wùdù kɛ, dá (xxx) xxx-xxxx.

Bengali (বাংলা)**:** যদি এই তথ্য পুস্তিকার বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য কল করুন (xxx) xxx-xxxx

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အခမဲ့အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (xxx) xxx-xxxx သို့ ခေါ်ဆိုပါ။

Chinese (中文)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電 (xxx) xxx-xxxx。

Dinka (Dinka): Na nɔŋ thiëëc në ke de yä thorë, ke yin nɔŋ loŋ bë yi kuony ku wɛr alëu bë gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kɔr yin ba jam wënë ran ye thok geryic, ke yin cɔl (xxx) xxx-xxxx.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (xxx) xxx-xxxx.

Farsi (فارسي) : در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (xxx) xxx-xxxx تماس بگیرید.

Language Access Services:

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (xxx) xxx-xxxx.

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (xxx) xxx-xxxx.

Greek (Ελληνικά) Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (xxx) xxx-xxxx.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (xxx) xxx-xxxx.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (xxx) xxx-xxxx.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (xxx) xxx-xxxx ।

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (xxx) xxx-xxxx.

Igbo (Igbo): Ọ bụr ụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (xxx) xxx-xxxx.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (xxx) xxx-xxxx.

Indonesian (Bahasa Indonesia): Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (xxx) xxx-xxxx.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (xxx) xxx-xxxx

Language Access Services:

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(xxx) xxx-xxxx　　にお電話ください。

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅ (xxx) xxx-xxxx　　។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (xxx) xxx-xxxx.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (xxx) xxx-xxxx 로 문의하십시오.

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄຳຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອໂອ້ລົມກັບລ່າມແປພາສາ, ໃຫ້ໂທຫາ (xxx) xxx-xxxx.

Navajo (Diné): Díí naaltsoos bikáʼígíí łahgo bínaʼídiłkidgo ná bohónéedzą́ dóó bee ahóótʼiʼ tʼáá ni nizaad kʼehjí bee nił hodoonih tʼáadoo bą́ą́h ílínígóó. Ataʼ halneʼígíí łaʼ bichʼį́ʼ hadeesdzih nínízingo kojį́ʼ hodíílnih (xxx) xxx-xxxx.

Nepali (नेपाली): यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ। दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (xxx) xxx-xxxx

Oromo (Oromifaa): Sanadi kanaa wajiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (xxx) xxx-xxxx bilbilla.

Pennsylvania Dutch (Deitsch): Wann du Frooge iwwer selle Document hoscht, du hoscht die Recht um Helfe un Information zu griege in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff (xxx) xxx-xxxx aa.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer (xxx) xxx-xxxx.

Portuguese (Português): Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para (xxx) xxx-xxxx.

Language Access Services:

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (xxx) xxx-xxxx ਤੇ ਕਾਲ ਕਰੋ।

Romanian (Română): Dacă aveți întrebări referitoare la acest document, aveți dreptul să primiți ajutor și informații în limba dumneavoastră în mod gratuit. Pentru a vă adresa unui interpret, contactați telefonic (xxx) xxx-xxxx.

Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (xxx) xxx-xxxx.

Samoan (Samoa): Afai e iai ni ou fesili e uiga i lenei tusi, e iai lou ‘aia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se totogi. Ina ia talanoa i se tagata faaliliu, vili (xxx) xxx-xxxx.

Serbian (Srpski): Ukoliko imate bilo kakvih pitanja u vezi sa ovim dokumentom, imate pravo da dobijete pomoć i informacije na vašem jeziku bez ikakvih troškova. Za razgovor sa prevodiocem, pozovite (xxx) xxx-xxxx.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (xxx) xxx-xxxx.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (xxx) xxx-xxxx.

Thai (ไทย): หากท่านมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร (xxx) xxx-xxxx เพื่อพูดคุยกับล่าม

Ukrainian (Українська): якщо у вас виникають запитання з приводу цього документа, ви маєте право безкоштовно отримати допомогу й інформацію вашою рідною мовою. Щоб отримати послуги перекладача, зателефонуйте за номером: (xxx) xxx-xxxx.

Urdu (اردو): اگر اس دستاویز کے بارے میں آپ کا کوئی سوال ہے، تو آپ کو مدد اور اپنی زبان میں مفت معلومات حاصل کرنے کا حق حاصل ہے۔ کسی مترجم سے بات کرنے کے لئے، (xxx) xxx-xxxx پر کال کریں۔

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (xxx) xxx-xxxx.

Language Access Services:

(Yiddish) (אידיש): אויב איר האט שאלות וועגן דעם דאקומענט, האט איר די רעכט צו באקומען דעם אינפארמאציע אין אייער שפראך אהן קיין פרייז. צו רעדן צו אן איבערזעצער, רופט xxx-xxxx (xxx).

Yoruba (Yorùbá): Tí o bá ní èyíkéyìí ìbèrè nípa àkọsílẹ̀ yìí, o ní ẹ̀tọ́ láti gba ìrànwọ́ àti ìwífún ní èdè rẹ lọ́fẹ̀ẹ́. Bá wa òǵbùfọ̀ kan sọ̀rọ̀, pe (xxx) xxx-xxxx.

Language Access Services:

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That's why we follow federal civil rights laws in our health programs and activities. We don't 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 isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services 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. Or you can 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.