

# Your summary of benefits



Matthew Thornton Health Plan, Inc./Anthem® Blue Cross and Blue Shield

Your 2026 Contract Code: 94M5

Your Plan: Anthem Silver Pathway X HMO 4000/0%/9000

Your Network: Pathway X

*This summary of benefits is a brief outline of coverage, designed to help you with the selection process. Unless stated otherwise, services received in an office, Site of Service Provider, or outpatient facility are combined across all outpatient settings. 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 Certificate of Insurance or Evidence of Coverage (EOC). If there is a difference between this summary and the Certificate of Insurance or Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.*

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
<b>Primary Care, and medical services for urgent/acute care</b>	\$25 copay per visit deductible does not apply
<b>Mental Health &amp; Substance Use Disorder Services</b>	\$25 copay per visit deductible does not apply
<b>Specialist care</b>	\$60 copay per visit deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<b>Overall Deductible</b>	\$4,000 person / \$8,000 family	Not covered
<b>Overall Out-of-Pocket Limit</b> <i>When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period.</i>	\$9,000 person / \$18,000 family	Not covered
<i>The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per member deductible and per member out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per member deductible or per member out-of-pocket limit.</i>		
<i>Your copays, coinsurance and deductible count toward your out-of-pocket limit. However, member cost sharing for the following service(s) do not apply toward the out-of-pocket limit: adult vision.</i>		
<i>Benefits are based on the setting in which covered services are received and how the provider bills.</i>		
<b>Doctor Visits (virtual and office)</b> <i>Your plan requires the selection of a Primary Care Physician (PCP). For members up to age 19, visits with In-Network Providers for primary care and mental health and substance use disorder services are covered at no charge.</i>		
<b>Preferred PCP</b> <i>virtual and office</i>	No charge	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<b>Primary Care (PCP)</b> <i>virtual and office</i>	\$30 copay per visit deductible does not apply	Not covered
<b>Mental Health and Substance Use Disorder Services</b> <i>virtual and office</i>	\$25 copay per visit deductible does not apply	Not covered
<b>Specialist Provider</b> <i>virtual and office</i>	\$60 copay per visit deductible does not apply	Not covered
<b>Other Practitioner Visits</b> Maternity Doctor services (prenatal/postpartum care and delivery) <i>In-Network preventive prenatal services are covered at 100%.</i> Retail Health Clinic  Chiropractic Services <i>Coverage is limited to 36 visits per benefit period. Benefit limit does not apply to Osteopathic manipulative treatment.</i> Acupuncture <i>Coverage is limited to 20 visits per benefit period.</i>	No charge after deductible is met  \$30 copay per visit deductible does not apply  \$30 copay per visit deductible does not apply  \$30 copay per visit deductible does not apply	Not covered  Not covered  Not covered  Not covered
<b>Other Services in an Office</b>  Allergy Testing  Prescription Drugs - Dispensed in the office <i>For the drugs itself dispensed in the office through infusion/injection.</i>  Surgery	No charge after deductible is met  No charge after deductible is met  No charge after deductible is met	Not covered  Not covered  Not covered
<b>Preventive care / screenings / immunizations</b>	No charge	Not covered
<b>Preventive care for Chronic Conditions</b> <i>per IRS guidelines</i>	No charge	Not covered
<b>Diagnostic Services Lab</b>  Office  Site of Service Provider  Outpatient Hospital	No charge  No charge  No charge after deductible is met	Not covered  Not covered  Not covered
<b>Diagnostic Services X-Ray</b>  Office  Site of Service Provider	No charge after deductible is met  No charge	Not covered  Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Outpatient Hospital	No charge after deductible is met	Not covered
<p><b><u>Diagnostic Services Advanced Diagnostic Imaging</u></b> - for example: MRI, PET and CAT scans</p> <p>Office</p> <p>Site of Service Provider</p> <p>Outpatient Hospital</p>	<p>No charge after deductible is met</p> <p>No charge</p> <p>No charge after deductible is met</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p><b><u>Urgent Care</u></b></p> <p><b>Walk-in Center/Walk-in Doctor's Office Visit</b></p> <p><b>Urgent Care Center Visit</b> <i>In-Network Urgent Care benefit limited to preferred New Hampshire locations. Cost may vary by site of service.</i></p> <p><b>Other Urgent Care Services</b></p> <p><b><u>Emergency Care</u></b></p> <p><b>Emergency Room Facility Services</b> <i>Your copay will be waived if admitted.</i></p> <p><b>Emergency Room Doctor and Other Services</b></p> <p><b>Emergency Room Doctor Services for Mental Health and Substance Use Disorders</b></p> <p><b>Ambulance Transportation</b> <i>Authorized Out-of-Network non-emergency ambulance services are limited to an Anthem maximum payment of \$50,000 per trip. The \$50,000 limit does not apply to air ambulance services.</i></p>	<p>\$30 copay per visit deductible does not apply</p> <p>\$100 copay per visit deductible does not apply</p> <p>No charge after deductible is met</p> <p>\$350 copay per visit after deductible is met</p> <p>No charge after deductible is met</p> <p>\$30 copay per visit after deductible is met</p> <p>No charge after deductible is met</p>	<p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p><b><u>Outpatient Mental Health and Substance Use Disorder Services at a Facility</u></b></p> <p><b>Facility Fees</b></p> <p><b>Doctor Services</b></p>	<p>No charge after deductible is met</p> <p>No charge after deductible is met</p>	<p>Not covered</p> <p>Not covered</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<p><b><u>Outpatient Surgery</u></b></p> <p><b>Facility Fees</b></p> <p>Hospital</p> <p>Site of Service Provider</p> <p><b>Physician and other services including surgeon fees</b></p> <p>Hospital</p> <p>Site of Service Provider</p>	<p>\$500 copay per visit after deductible is met</p> <p>No charge</p> <p>No charge after deductible is met</p> <p>No charge</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p><b><u>Hospital Stay (all Inpatient stays including Maternity, Mental Health and Substance Use Disorder Services)</u></b></p> <p><b>Facility fees (for example, room &amp; board)</b>  <i>Coverage for Skilled Nursing and Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is limited to 100 days combined per benefit period.</i></p> <p><b>Physician and other services including surgeon fees</b></p>	<p>No charge after deductible is met</p> <p>No charge after deductible is met</p>	<p>Not covered</p> <p>Not covered</p>
<p><b><u>Home Health Care</u></b>  <i>Coverage excludes Private Duty nursing services.</i></p>	<p>No charge after deductible is met</p>	<p>Not covered</p>
<p><b><u>Therapy Services</u></b></p> <p><b>Rehabilitation services (for example, physical/speech/occupational therapy)</b>  <i>Coverage for physical therapy, occupational therapy and speech therapy is limited to 60 visits combined per benefit period.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$30 copay per visit deductible does not apply</p> <p>No charge after deductible is met</p>	<p>Not covered</p> <p>Not covered</p>
<p><b>Habilitation services (for example, physical/speech/occupational therapy)</b>  <i>Coverage for physical therapy, occupational therapy and speech therapy is limited to 60 visits combined per benefit period.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$30 copay per visit deductible does not apply</p> <p>No charge after deductible is met</p>	<p>Not covered</p> <p>Not covered</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<b>Pulmonary rehabilitation</b>  Office  Outpatient Hospital	\$60 copay per visit deductible does not apply  No charge after deductible is met	Not covered  Not covered
<b>Cardiac rehabilitation</b>  Office  Outpatient Hospital	\$60 copay per visit deductible does not apply  No charge after deductible is met	Not covered  Not covered
<b>Dialysis/Hemodialysis</b> office and outpatient hospital	No charge after deductible is met	Not covered
<b>Chemo/Radiation Therapy</b> office and outpatient hospital	No charge after deductible is met	Not covered
<b>Skilled Nursing Care (in a facility)</b> <i>Coverage for Skilled Nursing and Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is limited to 100 days combined per benefit period.</i>	No charge after deductible is met	Not covered
<b>Inpatient Hospice</b>	No charge after deductible is met	Not covered
<b>Durable Medical Equipment</b>	No charge after deductible is met	Not covered
<b>Prosthetic Devices</b>	No charge after deductible is met	Not covered

Covered Prescription Drug Benefits	Cost if you use a Tier 1 In-Network Pharmacy	Cost if you use a Tier 2 In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
<b>Pharmacy Deductible</b>	Not applicable	Not applicable	Not covered
<b>Pharmacy Out-of-Pocket Limit</b>	Combined with In-Network medical out-of-pocket limit	Combined with In-Network medical out-of-pocket limit	Not covered
<b>Prescription Drug Coverage</b> <b>Network: Rx Choice Tiered Network</b> <b>Drug List: Select</b> Drugs not included on the Select drug list will not be covered. Prescription Drugs that we are required to cover by federal law under the "Preventive Care" benefit will be covered with no deductible, copayments or coinsurance when you use an In-Network Pharmacy.			
<b>Day Supply Limits:</b> <b>Retail Pharmacy</b> 30 day supply (cost shares noted below) <b>Retail 90 Pharmacy</b> 90 day supply (cost shares noted below) <b>Home Delivery Pharmacy</b> 90 day supply (maximum cost shares noted below). Maintenance medications are available through our 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. <b>Specialty Pharmacy</b> 30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.			
<b>Tier 1a - Typically Lower Cost Generic</b> Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at Tier 1 In-Network and Tier 2 In-Network Retail Pharmacies.	\$3 copay per prescription (retail) and \$6 copay per prescription (home delivery)	\$13 copay per prescription (retail only)	Not covered
<b>Tier 1b - Typically Generic</b> Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at Tier 1 In-Network and Tier 2 In-Network Retail Pharmacies.	\$25 copay per prescription (retail) and \$50 copay per prescription (home delivery)	\$35 copay per prescription (retail only)	Not covered
<b>Tier 2 - Typically Preferred Brand</b> Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at Tier 1 In-Network and Tier 2 In-Network Retail Pharmacies.	\$80 copay per prescription (retail) and \$160 copay per prescription (home delivery)	\$90 copay per prescription (retail only)	Not covered
<b>Tier 3 - Typically Non-Preferred Brand</b> Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at Tier 1 In-Network and Tier 2 In-Network Retail Pharmacies.	30% coinsurance up to \$400 per prescription (retail) and 30% coinsurance up to \$800 per prescription (home delivery)	40% coinsurance up to \$500 per prescription (retail only)	Not covered
<b>Tier 4 - Typically Specialty (brand and generic)</b>	40% coinsurance up to \$550 per	50% coinsurance up to \$650 per	Not covered

Covered Prescription Drug Benefits	Cost if you use a Tier 1 In-Network Pharmacy	Cost if you use a Tier 2 In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
	prescription (retail and home delivery)	prescription (retail only)	

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<p><i>This is a brief outline of your vision coverage. Not all cost shares for covered services are shown below. Benefits include coverage for member's choice of eyeglass lenses or contact lenses, but not both. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail. Only children's vision services count towards your out-of-pocket limit.</i></p>		
<p><b>Children's Vision Essential Health Benefits (up to age 19)</b></p>		
<p><b>Child Vision Deductible</b></p> <p><b>Vision Exam</b>  <i>Coverage for In-Network Providers is limited to 1 exam per benefit period.</i></p>	<p>Not applicable            No charge</p>	<p>Not applicable            Not covered</p>
<p><b>Frames</b>  <i>Coverage for In-Network Providers is limited to 1 unit per benefit period.</i></p>	<p>No charge</p>	<p>Not covered</p>
<p><b>Single Vision Lenses</b>  <i>Coverage for In-Network Providers is limited to 1 unit per benefit period.</i></p>	<p>No charge</p>	<p>Not covered</p>
<p><b>Bifocal Vision Lenses</b>  <i>Coverage for In-Network Providers is limited to 1 unit per benefit period.</i></p>	<p>No charge</p>	<p>Not covered</p>
<p><b>Trifocal Vision Lenses</b>  <i>Coverage for In-Network Providers is limited to 1 unit per benefit period.</i></p>	<p>No charge</p>	<p>Not covered</p>
<p><b>Elective Contact Lenses</b>  <i>Coverage for In-Network Providers is limited to 1 unit per benefit period.</i></p>	<p>No charge</p>	<p>Not covered</p>
<p><b>Non-Elective Contact Lenses</b>  <i>Coverage for In-Network Providers is limited to 1 unit per benefit period.</i></p>	<p>No charge</p>	<p>Not covered</p>
<p><b>Adult Vision (age 19 and older)</b></p>		
<p><b>Adult Vision Deductible</b></p> <p><b>Vision Exam</b>  <i>Coverage for In-Network Providers is limited to 1 exam per benefit period.</i></p>	<p>Not applicable            \$20 copay</p>	<p>Not applicable            Not covered</p>
<p><b>Frames</b>  <i>Coverage for In-Network Providers is limited to 1 unit every 2 benefit periods.</i></p>	<p>\$130 Allowance</p>	<p>Not covered</p>
<p><b>Single Vision Lenses</b>  <i>Coverage for Eye Glass Lenses or Contact Lens In-Network Providers is limited to 1 unit every 2 benefit periods.</i></p>	<p>\$20 copay</p>	<p>Not covered</p>
<p><b>Bifocal Vision Lenses</b>  <i>Coverage for Eye Glass Lenses or Contact Lens In-Network Providers is limited to 1 unit every 2 benefit periods.</i></p>	<p>\$20 copay</p>	<p>Not covered</p>
<p><b>Trifocal Vision Lenses</b>  <i>Coverage for Eye Glass Lenses or Contact Lens In-Network Providers is limited to 1 unit every 2 benefit periods.</i></p>	<p>\$20 copay</p>	<p>Not covered</p>
<p><b>Elective Contact Lenses</b></p>	<p>\$80 Allowance</p>	<p>Not covered</p>

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<i>Coverage for Eye Glass Lenses or Contact Lens In-Network Providers is limited to 1 unit every 2 benefit periods.</i>		
<b>Non-Elective Contact Lenses</b> <i>Coverage for Eye Glass Lenses or Contact Lens In-Network Providers is limited to 1 unit every 2 benefit periods.</i>	No charge	Not covered

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<p><i>This is a brief outline of your dental coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/ Disclosure form/ Certificate. If there is a difference between this summary and either Evidence of Coverage/ Disclosure form/ Certificate, the Evidence of Coverage/ Disclosure form/ Certificate will prevail. Only children's dental services count towards your out-of-pocket limit.</i></p>		
<p><b>Children's Dental Essential Health Benefits</b></p>		
<p><b>Diagnostic and preventive</b>  <i>Coverage for In-Network Providers is limited to 2 visits per 12 months.</i></p>	<p>0% coinsurance after deductible is met</p>	<p>Not covered</p>
<p><b>Basic services</b></p>	<p>40% coinsurance after deductible is met</p>	<p>Not covered</p>
<p><b>Major services</b></p>	<p>50% coinsurance after deductible is met</p>	<p>Not covered</p>
<p><b>Medically Necessary Orthodontia services</b></p>	<p>50% coinsurance after deductible is met</p>	<p>Not covered</p>
<p><b>Cosmetic Orthodontia services</b></p>	<p>Not covered</p>	<p>Not covered</p>
<p><b>Deductible</b></p>	<p>Combined with medical deductible</p>	<p>Not covered</p>
<p><b>Adult Dental</b></p>		
<p><b>Diagnostic and preventive</b></p>	<p>Not covered</p>	<p>Not covered</p>
<p><b>Basic services</b></p>	<p>Not covered</p>	<p>Not covered</p>
<p><b>Major services</b></p>	<p>Not covered</p>	<p>Not covered</p>
<p><b>Deductible</b></p>	<p>Not covered</p>	<p>Not covered</p>
<p><b>Annual maximum</b></p>	<p>Not covered</p>	<p>Not covered</p>

## Healthy Support & Rewards

To see your rewards and additional information log into the Anthem website at [anthem.com](https://www.anthem.com) or call the customer service number on your member ID card.

- Additional rules and limitations may apply to incentives such as requiring completion of multiple activities in order to earn the rewards.
- You should consult with a tax professional for possible tax implications.

<b>Program Name</b>	<b>Program Description</b>	<b>Program Incentive</b>
<b>Smart Rewards (Wellbeing Solutions Engagement Package 200)</b>	Subscriber and spouse/domestic partner may earn rewards when eligible activities are completed and, in some instances, are verified by an Anthem claim.	Up to \$200 per member per year
<b>Gym Reimbursement</b>	Subscriber, spouse, and dependents age 18 and over can get money back for using a gym. Fitness membership dues, up to \$400, are covered if you're a member of this plan. Work out 50 times at a qualifying fitness center for each six-month period within your benefit plan year. Benefit plan year is the yearly period of coverage that starts at the effective date of coverage.	

## Notes:

- Benefit period refers to calendar year.
- For additional information on this plan, please visit [www.sbc.anthem.com](http://www.sbc.anthem.com) to obtain a “Summary of Benefits and Coverage”.
- This plan needs further review for Massachusetts Minimum Credible Coverage (MCC) measures based on preliminary MA guidance. The final determination of whether a plan meets or does not meet MCC is up to the determination of the Massachusetts Health Connector. This document should not be used for tax purposes.
- You can save money on In-Network lab tests, x-rays, ultrasounds, Advanced Diagnostic imaging, and outpatient surgery. Visit <https://www.anthem.com/siteofservicenh/> or view your SBC for plan details.
- To view your prescription formulary list log on to <http://www.anthem.com/pharmacyinformation/>
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under “Outpatient Facility Services” which is generally coinsurance or coinsurance after your deductible is met.
- Early Childhood Intervention Services are covered for members up to age 3. Early Childhood Intervention Therapies are limited to 40 visits per benefit period.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits. Out-of-Network Benefits are not applicable.
- Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, 3D mammography, breast ultrasounds and MRIs are covered in full as required by state mandate.
- This health plan includes an Employee Assistance Program (EAP) to support your emotional health and wellness with work life resources, including one-on-one counseling by phone, in person and online. Three counseling visits are available at no charge to a member. EAP member service is accessible 24/7/365.

**Exclusions:** The services listed below are not covered by this plan. Complete details on exclusions and limitations are stated in the Subscriber Certificate.

- Any service that is not medically necessary.
- Any service required by a third party (court ordered services are covered if all of the other terms of the plan are met).
- Cosmetic surgery.
- Custodial or convalescent care.
- Educational testing and therapy.
- Experimental and/or investigational services except as required by law for clinical trials.
- Hospitalization for conditions that are not covered.
- Human organ transplants other than those listed in the Subscriber Certificate as Covered Services.
- Miscellaneous devices, materials, and supplies, including, but not limited to, dentures and support devices for the feet and corrective shoes.
- Permanent dental restoration, most oral surgery (general anesthesia, hospital or surgical day care facility charges for dental procedures are covered for certain individuals only to the extent required by law).
- Personal comfort items.
- Radial keratotomy or other surgery to correct vision.
- Routine podiatry footcare unless medically necessary.
- Services covered by government programs to the extent permitted by law.
- Services for work-related illness or injury.
- Services, treatments, procedures or programs for weight or appetite control, weight loss, weight management or control of obesity, except for diabetes education, nutrition counseling, and medically necessary surgical and non-surgical services to treat diseases and ailments caused by or resulting from obesity or morbid obesity.

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Questions: (855) 748-1805 or visit us at [www.anthem.com](http://www.anthem.com)

NH/SG/Anthem Silver Pathway X HMO 4000/0%/9000/94M5/2026

## We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

### Spanish

Usted tiene derecho a obtener asistencia en su idioma sin cargo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación ¿Tiene alguna deficiencia visual? También puede solicitar este documento en otros formatos.

### Chinese

您有權免費獲得使用您的語言提供的協助。只需撥打印於您的 ID 卡上的會員服務部電話號碼即可。視力障礙？您也可以索取本文件的其他格式。

### Vietnamese

Quý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, miễn phí. Quý vị chỉ cần gọi đến số điện thoại của Ban Dịch vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm thị? Quý vị cũng có thể yêu cầu các định dạng khác của tài liệu này.

### Korean

귀하는 귀하의 언어로 된 도움을 무료로 받을 권리가 있습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로 전화하십시오. 시각 장애인이신가요? 다른 형식으로 된 이 문서를 요청하실 수 있습니다.

### Tagalog

May karapatan kang makakuha ng tulong na nasa iyong wika nang libre. Tawagan lang ang numero ng Member Services na nasa iyong ID card. May kapansanan sa paningin? Maaari ka ring humingi ng iba pang mga format ng dokumentong ito.

### Russian

У вас есть право на бесплатное получение помощи на вашем родном языке. Просто позвоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. У вас проблемы со зрением? Вы также можете запросить этот документ в других форматах.

### French Creole

Ou gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo Sèvis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? Ou ka mande tou pou lòt fòm nan dokiman sa a.

### Arabic

لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجانًا. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضًا طلب تنسيقات أخرى لهذه الوثيقة.

### French

Vous avez le droit d'obtenir de l'aide dans votre langue gratuitement. Appelez simplement le numéro du Services membres figurant sur votre carte d'identité. Vous êtes une personne malvoyante ? Vous pouvez également demander à accéder à ce document dans d'autres formats.

### Persian

شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره خدمات اعضا مندرج در کارت عضویت خود تماس بگیرید. آیا دچار اختلال بینایی هستید؟ همچنین می‌توانید فرمت‌های دیگر این سند را درخواست کنید.

### Armenian

Դուք իրավունք ունեք անվճար օգնություն ստանալու ձեր լեզվով: Դարձապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցող եք: Կարող եք նաև խնդրել այս փաստաթղթի այլ ձևաչափեր:

### Japanese

あなたにはあなたの言語で無料で支援を受ける権利があります。IDカードに記載されている会員サービス番号にお電話ください。視覚障害をお持ちですか？他の形式でこの文書を要求することもできます。

### Italian

Hai il diritto di ricevere assistenza gratuita nella tua lingua. Basta chiamare il numero del Servizio Membri presente sulla tua tessera identificativa. Hai problemi di vista? È possibile richiedere anche altri formati di questo documento.

### German

Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Rufen Sie einfach die Nummer des Mitgliederservices auf Ihrer ID-Karte an. Sehbehindert? Sie können dieses Dokument auch in anderen Formaten anfordern.

### Polish

Masz prawo do bezpłatnej pomocy w swoim języku. Wystarczy zadzwonić pod numer Biura Obsługi Klienta podany na karcie identyfikacyjnej. Masz wadę wzroku? Możesz również poprosić o inne formaty tego dokumentu.

### Pennsylvania Dutch

Du hoscht's Recht fer Hilf griege in dei Schprooch fer nix. Duh yuscht die Member Services Number uffrufe uff dei ID Card. Hoscht Druwwel fer sehne? Du kannscht des do Schreiwes in en differnter Weg griege so as du's besser sehne kannscht.

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