# Your summary of benefits

Anthem

Anthem® Blue Cross

Your 2027 Contract Code: 1GGP

Your Plan: Anthem Gold PPO 35/500/25%

Your Network: Prudent Buyer PPO

*This summary of benefits is a brief outline of coverage, designed to help you with the selection process. Unless stated otherwise, the limitations for In- and Out-of-Network services are combined and services received in an office, Ambulatory Surgical Center, 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 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.*

| Visits with Virtual Care-Only Providers | Cost through our mobile app and website |
|---|---|
| **Primary Care, and medical services for urgent/acute care** | No charge |
| **Mental Health & Substance Use Disorder Services** | No charge |
| **Specialist care** | $65 copay per visit medical deductible does not apply |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|---|---|---|
| **Overall Deductible**<br>*Your plan applies a separate Pharmacy Deductible to prescription drugs obtained at a pharmacy. See the Covered Prescription Drug Benefits section.* | $500 person / $1,500 family | $2,000 person / $4,000 family |
| **Overall Out-of-Pocket Limit**<br>*When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period.* | $8,200 person / $16,400 family | $16,400 person / $32,800 family |
| *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.*<br>*In-Network and Out-of-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.*<br>*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.* | | |
| **Doctor Visits (virtual and office)** *You are encouraged to select a Primary Care Physician (PCP).* | | |
| **Primary Care (PCP) and Mental Health and Substance Use Disorder Services** *virtual and office* | $35 copay per visit medical deductible does not apply | 50% coinsurance after medical deductible is met |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|---|---|---|
| **Specialist Provider** *virtual and office* | $65 copay per visit medical deductible does not apply | 50% coinsurance after medical deductible is met |
| **Other Practitioner Visits** | | |
| Maternity Doctor services | | |
| Prenatal care | No charge | 50% coinsurance after medical deductible is met |
| Delivery | 25% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| Postpartum care | $35 copay per visit medical deductible does not apply | 50% coinsurance after medical deductible is met |
| Retail Health Clinic Visit | $35 copay per visit medical deductible does not apply | 50% coinsurance after medical deductible is met |
| Chiropractic/Manipulation Therapy<br>*Coverage is limited to 20 visits per year.* | $15 copay per visit medical deductible does not apply | Not covered |
| Acupuncture | $35 copay per visit medical deductible does not apply | Not covered |
| **Other Services in an Office** | | |
| Allergy Testing | 25% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| Prescription Drugs - Dispensed in the office<br>*For the drugs itself dispensed in the office through infusion/injection. Maximum of $250 member cost share per drug.* | 25% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| Surgery | 25% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| **Preventive care / screenings / immunizations** | No charge | 50% coinsurance after medical deductible is met |
| **Preventive care for Chronic Conditions** *per IRS guidelines* | No charge | Cost share is based on the setting services are received. |
| **Diagnostic Services Lab** | | |
| Office<br>*Office Cost Share applies only when Freestanding/Reference Labs are not used.* | $15 copay per visit medical deductible does not apply | 50% coinsurance after medical deductible is met |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|---|---|---|
| Freestanding Lab/Reference Lab | No charge | 50% coinsurance after medical deductible is met |
| Outpatient Hospital<br>*Anthem's maximum payment is up to $380 per service for Out-of-Network Providers.* | 25% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| **Diagnostic Services X-Ray** | | |
| Office | $15 copay per visit medical deductible does not apply | 50% coinsurance after medical deductible is met |
| Freestanding Radiology Center | 25% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| Outpatient Hospital<br>*Anthem's maximum payment is up to $380 per service for Out-of-Network Providers.* | 25% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| **Diagnostic Services Advanced Diagnostic Imaging** - for example: MRI, PET and CAT scans | | |
| Office<br>*Anthem's maximum payment is up to $800 per service for Out-of-Network Providers.* | 25% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| Freestanding Radiology Center<br>*Anthem's maximum payment is up to $380 per admission for Out-of-Network providers.* | 25% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| Outpatient Hospital<br>*Anthem's maximum payment is up to $380 per admission for Out-of-Network providers.* | $100 copay per day and 25% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| **Emergency and Urgent Care** | | |
| **Urgent Care (Office Setting)** | $35 copay per visit medical deductible does not apply | 50% coinsurance after medical deductible is met |
| **Emergency Room Facility Services**<br>*Your copay will be waived if admitted.* | $250 copay per visit and 25% coinsurance after medical deductible is met | Covered as In-Network |
| **Emergency Room Doctor and Other Services** | 25% coinsurance after medical deductible is met | Covered as In-Network |
| **Ambulance Transportation** | 25% coinsurance after medical deductible is met | Covered as In-Network |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|---|---|---|
| **Outpatient Mental Health and Substance Use Disorder Services at a Facility** | | |
| **Facility Fees** | 25% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| **Doctor Services** | 25% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| **Outpatient Surgery** | | |
| **Facility Fees** | | |
| Hospital<br>*Anthem's maximum payment is up to $380 per service for Out-of-Network Providers.* | $250 copay per visit and 25% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| Ambulatory Surgical Center | $50 copay per visit and 25% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| **Physician and other services including surgeon fees** | | |
| Hospital | 25% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| Ambulatory Surgical Center | 25% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| **Hospital Stay (all Inpatient stays including Maternity, Mental Health and Substance Use Disorder Services)** | | |
| **Facility fees (for example, room & board)**<br>*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. Anthem's maximum payment is up to $650 per day for Out-of-Network providers.* | 25% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| **Physician and other services including surgeon fees** | 25% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| **Home Health Care**<br>*Home health visits are limited to 100 visits per benefit period. Benefit limit does not apply to physical, occupational or speech therapy when performed as part of Home Health. Limits are combined for home health care and private duty nursing. Anthem's maximum payment is up to $75 per visit for Out-of-Network.* | 25% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| **Therapy Services** | | |

| 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 | $35 copay per visit medical deductible does not apply | 50% coinsurance after medical deductible is met |
| Outpatient Hospital<br>*Anthem's maximum payment is up to $380 per admission for Out-of-Network providers.* | 25% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| **Habilitation services (for example, physical/speech/occupational therapy)** | | |
| Office | $35 copay per visit medical deductible does not apply | 50% coinsurance after medical deductible is met |
| Outpatient Hospital<br>*Anthem's maximum payment is up to $380 per admission for Out-of-Network providers.* | 25% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| **Pulmonary rehabilitation** | | |
| Office | $35 copay per visit medical deductible does not apply | 50% coinsurance after medical deductible is met |
| Outpatient Hospital<br>*Anthem's maximum payment is up to $380 per admission for Out-of-Network providers.* | 25% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| **Cardiac rehabilitation** | | |
| Office | $35 copay per visit medical deductible does not apply | 50% coinsurance after medical deductible is met |
| Outpatient Hospital<br>*Anthem's maximum payment is up to $380 per admission for Out-of-Network providers.* | 25% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| **Dialysis/Hemodialysis** office and outpatient hospital | 25% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| **Chemo/Radiation Therapy** office and outpatient hospital | 25% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| **Skilled Nursing Care (in a facility)**<br>*Coverage for Skilled Nursing and Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is limited to 100 days* | 25% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|---|---|---|
| *combined per benefit period. Anthem's maximum payment is up to $150 per day for admissions to Out-of-Network providers.* | | |
| **Inpatient Hospice** | No charge after medical deductible is met | 50% coinsurance after medical deductible is met |
| **Durable Medical Equipment** | 50% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |

| Covered Prescription Drug Benefits | Cost if you use a Preferred Network Pharmacy | Cost if you use an In-Network Pharmacy | Cost if you use an Out-of-Network Pharmacy |
|---|---|---|---|
| **Pharmacy Deductible** *combined for Preferred Network and In-Network Pharmacies* | $250 person / $500 family (does not apply to Tier 1 drugs) | $250 person / $500 family (does not apply to Tier 1 drugs) | Not covered |
| **Pharmacy Out-of-Pocket Limit** | Combined with In-Network medical out-of-pocket limit | Combined with In-Network medical out-of-pocket limit | Not covered |
| **Prescription Drug Coverage**<br>**Network:** ***Rx Choice Tiered Network***<br>**Drug List:** ***Select*** *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.*<br>***For more information, refer to "Select Drug List" at*** *https://www.anthem.com/ca/pharmacy-information/*. | | | |
| **Day Supply Limits**<br>**Retail Pharmacy:** *30 day supply (cost shares noted below)*<br>**Retail 90 Pharmacy:** *90 day supply (cost shares noted below)*<br>**Home Delivery Pharmacy:** *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.*<br>**Specialty Pharmacy:** *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.* | | | |
| **Tier 1 - Typically Generic**<br>*Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies.* | $10 copay per prescription, Pharmacy deductible does not apply (retail) and $20 copay per prescription, Pharmacy deductible does not apply (home delivery) | $20 copay per prescription, Pharmacy deductible does not apply (retail only) | Not covered (retail and home delivery) |
| **Tier 2 - Typically Preferred Brand**<br>*Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies.* | $50 copay per prescription after Pharmacy deductible is met (retail) and $125 copay per prescription after Pharmacy deductible is met (home delivery) | $60 copay per prescription after Pharmacy deductible is met (retail only) | Not covered (retail and home delivery) |
| **Tier 3 - Typically Non-Preferred Brand**<br>*Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies.* | $90 copay per prescription after Pharmacy deductible is met (retail) and $225 copay per prescription after Pharmacy deductible | $100 copay per prescription after Pharmacy deductible is met (retail only) | Not covered (retail and home delivery) |

| Covered Prescription Drug Benefits | Cost if you use a Preferred Network Pharmacy | Cost if you use an In-Network Pharmacy | Cost if you use an Out-of-Network Pharmacy |
|---|---|---|---|
| | is met (home delivery) | | |
| **Tier 4 - Typically Specialty (brand and generic)** | 30% coinsurance up to $250 per prescription after Pharmacy deductible is met (retail and home delivery) | 40% coinsurance up to $250 per prescription after Pharmacy deductible is met (retail only) | Not covered (retail and home delivery) |

| Covered Vision Benefits | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|---|---|---|
| *This is a brief outline of your vision coverage. Not all cost shares for covered services are shown below. Benefits include coverage for member's choice of eyeglass lenses or contact lenses, but not both. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail. Only children's vision services count towards your out-of-pocket limit.* | | |
| **Children's Vision Essential Health Benefits (up to age 19)** | | |
| **Child Vision Deductible** | Not applicable | Not applicable |
| **Vision Exam**<br>*Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 exam per benefit period.* | No charge | $0 copayment up to plan's Maximum Allowed Amount |
| **Frames**<br>*Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.* | No charge | $0 copayment up to plan's Maximum Allowed Amount |
| **Single Vision Lenses**<br>*Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.* | No charge | $0 copayment up to plan's Maximum Allowed Amount |
| **Bifocal Vision Lenses**<br>*Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.* | No charge | $0 copayment up to plan's Maximum Allowed Amount |
| **Trifocal Vision Lenses**<br>*Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.* | No charge | $0 copayment up to plan's Maximum Allowed Amount |
| **Elective Contact Lenses**<br>*Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.* | No charge | $0 copayment up to plan's Maximum Allowed Amount |
| **Non-Elective Contact Lenses**<br>*Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.* | No charge | $0 copayment up to plan's Maximum Allowed Amount |
| **Adult Vision (age 19 and older)** | | |
| **Adult Vision Deductible** | Not applicable | Not applicable |
| **Vision Exam**<br>*Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 exam per benefit period.* | No charge | Reimbursed Up to $30 |
| **Frames** | Not covered | Not covered |
| **Single Vision Lenses** | Not covered | Not covered |
| **Bifocal Vision Lenses** | Not covered | Not covered |
| **Trifocal Vision Lenses** | Not covered | Not covered |
| **Elective Contact Lenses** | Not covered | Not covered |
| **Non-Elective Contact Lenses** | Not covered | Not covered |

| Covered Dental Benefits | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|---|---|---|
| *This is a brief outline of your dental coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail. Only children's dental services count towards your out-of-pocket limit.* | | |
| **Children's Dental Essential Health Benefits**<br>**Diagnostic and preventive**<br>*Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 visit per 6 months.* | No charge | No charge |
| **Basic services** | 20% coinsurance<br>dental deductible does not apply | 20% coinsurance<br>dental deductible does not apply |
| **Major services** | 50% coinsurance<br>dental deductible does not apply | 50% coinsurance<br>dental deductible does not apply |
| **Medically Necessary Orthodontia services** | 50% coinsurance<br>dental deductible does not apply | 50% coinsurance<br>dental deductible does not apply |
| **Cosmetic Orthodontia services** | Not covered | Not covered |
| **Deductible** | $0 | $0 |
| **Adult Dental**<br>**Diagnostic and preventive** | Not covered | Not covered |
| **Basic services** | Not covered | Not covered |
| **Major services** | Not covered | Not covered |
| **Deductible** | Not covered | Not covered |
| **Annual maximum** | Not covered | Not covered |

**Notes:**

- The representation of benefits in this document is subject to state and federal regulatory approvals and are subject to change.
- Benefit period refers to calendar year.
- For additional information on this plan, please visit www.sbc.anthem.com to obtain a "Summary of Benefits and Coverage".
- If services are rendered by a non-participating provider and your plan includes Out-of-Network benefits, you may be responsible for any difference between the covered plan payment and the actual non-participating provider's charge.
- For plans with an office visit copay, the copay applies to the actual office visit and additional cost shares may apply for any other service performed in the office (i.e., X-ray, lab, surgery), after any applicable deductible.
- 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.
- Certain services are subject to the utilization review program or precertification. Before scheduling services, the member must make sure utilization or precertification review is obtained. If utilization or precertification review is not obtained, benefits may be reduced or not paid according to the plan.
- You must get certain covered transplant procedures from an Approved In-Network Provider to receive the In-Network level of benefits.
- Coverage includes standard fertility preservation services as a basic healthcare service including but are not limited to, injections, cryopreservation and storage for both male and female members when a medically necessary treatment may cause iatrogenic infertility. Member cost share for fertility preservation services is based on provider type and service rendered.
- 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.

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Questions: (855) 383-7248 or visit us at www.anthem.com/ca

CA/SG/Anthem Gold PPO 35/500/25%/1GGP/2027

## Get help in your language

**Language Assistance Services**
Curious to know what all this says?
We would be too. Here's the English version:
IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help with translations or interpreter services, in a timely manner, please call the telephone number on the back of your ID card. (TTY/TDD:711)

Separate from our language assistance program, we make documents available in alternative 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.

**Spanish**

IMPORTANTE: ¿Puede leer esta carta? Si no es así, podemos pedirle a alguien que lo ayude a leerla. También puede recibir esta carta escrita en su idioma. Para obtener ayuda oportuna y gratuita con traducciones o servicios de interpretación, llame al número de teléfono que figura en el dorso de su tarjeta de identificación. (TTY/TDD: 711).

**Arabic**

هام: هل يمكنك قراءة هذه الرسالة؟ إذا لم يكن الأمر كذلك، فيمكننا أن نطلب من شخص ما مساعدتك في قراءتها. قد تتمكن أيضا من الحصول على هذه الرسالة مكتوبة بلغتك. للحصول على مساعدة مجانية في خدمات الترجمة أو الترجمة الفورية، في الوقت المناسب، يرجى الاتصال برقم الهاتف الموجود على ظهر بطاقة الهوية الخاصة بك. (TTY/TDD:711).

**Armenian**

ԿԱՐԵՎՈՐ Է. կարողանո՞ւմ եք կարդալ այս նամակը: Եթե ոչ, կարող ենք օգնել ձեզ կարդալ այն: Դուք կարող եք նաև ստանալ այս նամակը գրավոր՝ ձեր լեզվով: Թարգմանությունների կամ թարգմանչական ծառայությունների անվճար օգնության համար, ժամանակին, խնդրում ենք զանգահարել ձեր ID քարտի հակառակ կողմում նշված հեռախոսահամարով: (TTY/TDD՝ 711):

**Chinese**

重要提示：您能讀懂這封信嗎？如果不能，我們可以請人幫您看。您還可以獲得以您的語言寫的此信件。如需及時獲得免費的翻譯或口譯服務協助，請撥打您 ID 卡背面的電話號碼。(TTY/TDD:711)。

**Farsi**

مهم: می‌توانید این نامه را بخوانید؟ اگر نه، می‌توانیم از کسی بخواهیم که در خواندن آن به شما کمک کند. همچنین ممکن است بتوانید این نامه را به زبان خودتان دریافت کنید. برای دریافت کمک رایگان و به‌موقع در زمینه خدمات ترجمه کتبی یا مترجم شفاهی، لطفاً با شماره تلفن مندرج در پشت کارت ID خود تماس بگیرید. (TTY/TDD:711).

**Hindi**

महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? यदि नहीं, तो हम किसी को इसे पढ़ने में आपकी सहायता करने के लिए रख सकते हैं। आप इस पत्र को अपनी भाषा में भी लिखवा सकते हैं। अनुवाद या दुभाषिया सेवाओं के संबंध में समय पर निःशुल्क सहायता के लिए कृपया अपने पहचान पत्र के पीछे दिए गए टेलीफोन नंबर पर कॉल करें। (TTY/TDD:711)।

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**Hmong**
TSEEM CEEB: Koj puas yeem nyeem tau tsab ntawv no? Yog tias nyeem tsis tau, peb mam kom lwm tus neeg los pab nyeem rau koj. Koj hais tau kom muab tsab ntawv no sau ua koj yam lus. Rau kev pab txhais ntawv los sis txhais lus pab dawb, kom raws sij hawm, thov hu tus npawb xov tooj nyob sab nraum qab ntawm koj daim npav ID. (TTY/TDD: 711).

**Japanese**
重要：この手紙は読めますか？そうでない場合は、誰かに読んでもらうのを手伝ってもらうこともできます。このお知らせは、貴方の言語で受け取ることも可能です。翻訳や通訳サービスの無料サポートをご希望の場合は、ID カードの裏面に記載されている電話番号までお電話ください。(TTY/TDD:711)。

**Khmer**
សំខាន់៖ តើអ្នកអាចអានសំបុត្រនេះបានទេ? បើអត់ទេ យើងអាចមានអ្នកជួយអ្នកឱ្យអានវាបាន។ អ្នកក៏ប្រហែលជាអាចឱ្យសំបុត្រនេះសរសេរជាភាសារបស់អ្នកបានផងដែរ។ ដើម្បីទទួលបានជំនួយដោយឥតគិតថ្លៃជាមួយនឹងការបកប្រែឬសេវាអ្នកបកប្រែផ្ទាល់មាត់ទាន់ពេលវេលា សូមទូរស័ព្ទទៅលេខនៅខាងក្រោយកាត ID របស់អ្នក។ (TTY/TDD:711)។

**Korean**
중요: 이 서신을 읽으실 수 있습니까? 그렇지 않다면 서신을 읽을 수 있게 도움을 드릴 수 있습니다. 원하시는 언어로 이 서신을 받으실 수도 있습니다. 번역이나 통역 서비스를 무료로 이용하시려면 적시에 ID 카드 뒷면에 있는 전화번호로 전화해 주십시오. (TTY/TDD: 711).

**Punjabi**
ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਵੀ ਲਿਖਵਾ ਸਕਦੇ ਹੋ। ਅਨੁਵਾਦ ਜਾਂ ਦੁਭਾਸ਼ੀਏ ਸੇਵਾਵਾਂ ਵਿੱਚ ਮੁਫ਼ਤ ਮਦਦ ਲਈ, ਸਮੇਂ ਸਿਰ, ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਟੈਲੀਫੋਨ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD:711).

**Russian**
ВАЖНАЯ ИНФОРМАЦИЯ: Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Чтобы своевременно получить бесплатные услуги письменного или устного перевода, позвоните по номеру телефона, указанному на оборотной стороне вашей идентификационной карты участника. (TTY/TDD: 711).

**Tagalog**
MAHALAGA: Nababasa mo ba ang sulat na ito? Kung hindi, maaari kaming kumuha ng taong tutulong sa iyo na basahin ito. Maaari mo ring ipasulat ang sulat na ito sa iyong wika. Para sa libreng tulong sa mga pagsasalin o serbisyo ng interpreter, sa isang napapanahong paraan, mangyaring tawagan ang numero ng telepono sa likod ng iyong ID card. (TTY/TDD:711).

**Thai**
ข้อสำคัญ: คุณสามารถอ่านจดหมายฉบับนี้ได้หรือไม่ ถ้าไม่ เราสามารถหาคนช่วยอ่านให้กับคุณได้ นอกจากนี้คุณยังสามารถขอให้เขียนจดหมายให้ได้ในภาษาของคุณเอง ขอรับบริการแปลหรือล่ามที่รวดเร็วได้ฟรี กรุณาติดต่อหมายเลขโทรศัพท์ที่ด้านหลังของบัตรประจำตัวของคุณ (TTY/TDD:711).

**Vietnamese**
QUAN TRỌNG: Quý vị có thể đọc lá thư này không? Nếu không, chúng tôi có thể nhờ ai đó giúp quý vị đọc thư. Quý vị cũng có thể yêu cầu viết lá thư này bằng ngôn ngữ của mình. Để được trợ giúp miễn phí về dịch vụ biên dịch hoặc thông dịch một cách kịp thời, vui lòng gọi số điện thoại ở mặt sau thẻ ID của quý vị. (TTY/TDD: 711).

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