

# The benefits Delawareans deserve

2023-2024 Sample Benefit Guide | Effective July 1, 2023  
Customer Service: 1-844-459-6452



Because Life.™



Delaware,

We know choosing coverage is about more than just your health care. It's about peace of mind. That's why when you choose Highmark Blue Cross Blue Shield Delaware, you get a plan that's simple to understand, easy to use, and easy to love.

With Highmark, you get access to personalized wellness programs, handy online tools, and 24/7 support for any questions you might have along the way. And, as always, you get a local network with 8 hospitals and over 4,000 doctors and specialists, right here in Delaware.

We look forward to making it easier for you to feel your best.

Nick Moriello  
President, Highmark Blue Cross Blue Shield Delaware

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# Three ways Highmark makes it simple.

1

## Nationwide access to providers through the BlueCard® program.

With your coverage, you get access to the largest physician and hospital networks in the U.S., including over 1.7 million providers and 95% of all hospitals.\* And when you travel, you're covered in 190 countries.

2

## Total support, day or night.

Whether it's 24/7 answers from registered nurses, access to virtual care for prescriptions or a diagnosis, or just some help booking your doctor visits, we're here when you need us.

3

## Easy access to top-performing specialists.

Many of our network specialists have Blue Distinction® status for their exceptional safety and results. That means great specialty care for you across the board.

\* According to the Blue Cross Blue Shield Association.

**There's the short version.**

For more details on what makes the choice even simpler, turn the page.

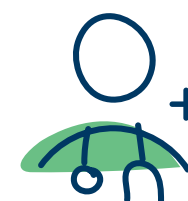
**Get the care you need,  
when you need it. It's  
coverage that goes  
where you go.**



#### MY CARE NAVIGATOR<sup>SM\*</sup>

## Your appointments, booked for you.

It's as simple as calling 1-844-459-6452. We'll help you find the in-network doctor you need and reserve some space on their calendar for a checkup. Which means less on-hold music for you.



#### NO REFERRALS

## No referrals, no red tape.

Lose the time wasting of going to an appointment just to get another appointment. See whichever in-network doctors you want to see. Or call 1-844-459-6452 and we'll find a specialist for you.



#### BLUE DISTINCTION SPECIALTY CARE

## See specialists who get better results.

Only those providers that first meet nationally established, objective quality measures for Blue Distinction Centers will be considered for designation as a Blue Distinction Center+. When searching on the Highmark member website, Blue Distinction icons indicate specialists who have earned the status for exceptional safety and results.



#### WELL360 VIRTUAL HEALTH

## Personalized care when and where you want it.

No more waiting rooms, no more waiting to schedule. Get care when and where you need it with Well360 Virtual Health. This solution lets you talk with a board-certified doctor in your area right away. Register on [well360virtualhealth.com](https://well360virtualhealth.com) or log in if you are already using the Amwell site.

Quick answers to all your questions, plus endless support on your road to better health.



#### BLUES ON CALL

## Answers from a health pro, 24/7.

Medical concerns during off hours? Just call 1-844-459-6452 to get support from a registered nurse or a health coach any time and put your worries to bed.



#### ONLINE TOOLS AND MEMBER WEBSITE

## Your entire plan at your fingertips.

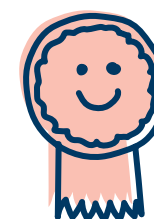
No more searching for old files or waiting on snail mail. Your digital ID card, Find a Doctor tool, deductible progress, and claims status are all available online at [highmarkbcbsde.com](https://highmarkbcbsde.com).



#### CARE COST ESTIMATOR

## See what care might cost you.

Before making an appointment for a test, scan, or procedure, Care Cost Estimator helps you estimate what that care may cost. Available on your member website, [highmarkbcbsde.com](https://highmarkbcbsde.com).



#### HEALTH COACHES

## Personalized support for health goals.

Looking to lose weight? Quit smoking? Be more active? A wellness coach can create a personalized plan for you, right over the phone, on your schedule. Sessions are free and confidential.

The benefits don't  
stop there. **More perks**  
coming your way.

[highmarkbcbsde.com](https://highmarkbcbsde.com)

Find out more about these benefits by logging in to your member website.

BLUE365<sup>SM</sup>

## Discounts to help you stay healthy and active.

From workout gear to personal wellness to healthy meal services, we'll take a little off the top while you're taking a little off your middle. Member-only deals are at [blue365deals.com](https://blue365deals.com).

COMPLEX CASE MANAGEMENT

## Help staying on track with treatments.

Our case managers are experts in making complex health situations simpler. They'll help you make a plan and stick to it.

SHARECARE<sup>®</sup>

## Say hello to your online health and wellness hub.

Find out your RealAge<sup>®</sup>, track your health habits, and monitor sleep, stress, and fitness — in real time. Get started at [mycare.sharecare.com](https://mycare.sharecare.com).

DISEASE MANAGEMENT AND DIABETES PREVENTION PROGRAMS

## Help managing chronic conditions.

Receive one-on-one nurse support for conditions like asthma, diabetes, heart disease, and other chronic conditions, either in person or virtually. Get tips on how to avoid diabetes and lower your risk with simple, effective, practical strategies.

# What's covered, what's free, and everything in between.

Our plans come with a ton of great benefits. And as part of your membership, there's no extra cost for most in-network preventive care. If you want more details, visit [highmarkbcbsde.com](http://highmarkbcbsde.com).

## Sample Basic Plan

This sample of benefits is intended to briefly highlight the health plans available. All percentages listed refer to Highmark Blue Cross Blue Shield Delaware's allowable charges.

| Description of Benefit   | In-Network Benefits  | Out-of-Network Benefits  |
|--|--|--|
| Deductibles – Plan Year  | \$500 Individual, \$1,000 Family   | \$1,000 Individual, \$2,000 Family   |
| Total Maximum Out-of-Pocket Expenses (TMOOP) Plan Year (includes deductibles, copays, and coinsurance) | \$2,000 Individual, \$4,000 Family   | \$4,000 Individual, \$8,000 Family   |
| Inpatient Room and Board   | 10% coinsurance after deductible <sup>1</sup>                              | 30% coinsurance after deductible <sup>2*</sup>                             |
| Inpatient Physician and Surgeon  |  |  |
| Outpatient Surgery   |  |  |
| Bariatric Surgery  | See footnote <sup>3,4</sup>  | See footnote <sup>3,4</sup>  |
| Hospice  | 10% coinsurance after deductible <sup>1*</sup>                             | 30% coinsurance after deductible <sup>2*</sup>                             |
| Home Care Services   | 10% coinsurance after deductible<br>240 visits per plan year <sup>1*</sup> | 30% coinsurance after deductible<br>240 visits per plan year <sup>2*</sup> |
| Emergency Services   | 10% coinsurance after deductible <sup>1</sup>                              | 10% coinsurance after deductible <sup>1</sup>                              |
| Urgent Care Services   | 100% covered after \$25 copay per visit                                    | 100% covered after \$25 copay per visit                                    |
| <b>Mental Health Care/Substance Abuse Treatment</b>  |  |  |
| Inpatient Hospital Care and Partial/Intensive Outpatient Care  | 10% coinsurance after deductible <sup>1*</sup>                             | 30% coinsurance after deductible <sup>2*</sup>                             |
| Outpatient Care  | 10% coinsurance after deductible <sup>1</sup>                              | 30% coinsurance after deductible <sup>2</sup>                              |
| Telemedicine Services  | 10% coinsurance after deductible   | 30% coinsurance after deductible   |

| Description of Benefit                                  | In-Network Benefits   | Out-of-Network Benefits  |
|---|---|--|
| <b>Other Services</b>                                   |   |  |
| Durable Medical Equipment                               | 10% coinsurance after deductible <sup>1</sup>   | 30% coinsurance after deductible <sup>2</sup>  |
| Skilled Nursing Facility                                | 10% coinsurance after deductible<br>120-day limit (renewable after 180 days) <sup>1*</sup>  | 30% coinsurance after deductible<br>120-day limit (renewable after 180 days) <sup>2*</sup>   |
| Emergency Ambulance                                     | 10% coinsurance after deductible <sup>1</sup>   | 30% coinsurance after deductible <sup>2</sup>  |
| Physician Home/Office Visits (sick)                     |   |  |
| Specialist Care   |   |  |
| Allergy Testing and Allergy Treatment                   |   |  |
| Lab <sup>***</sup> and X-Ray                            |   |  |
| MRIs, MRAs, CTs, CTAs<br>PET Scans and Imaging Studies  | 10% coinsurance after deductible<br>(Prior auth. required) <sup>1*</sup>  | 30% coinsurance after deductible <sup>2</sup>  |
| Short-Term Therapies:<br>Physical, Speech, Occupational | 10% coinsurance after deductible<br>(The maximum number of visits allowed for a specific diagnosis is determined by medical necessity) <sup>1</sup> | 30% coinsurance after deductible<br>(The maximum number of visits allowed for a specific diagnosis is determined by medical necessity)           |
| Annual Pap Smear and Gyn Exam                           | 100% covered <sup>5</sup>   | 30% coinsurance after deductible <sup>5</sup>  |
| Periodic Physical Exams, Immunizations                  |   |  |
| Mammograms – Routine                                    |   |  |
| Hearing Tests – Routine                                 | 100% covered <sup>5</sup>   | 30% coinsurance after deductible <sup>5</sup>  |
| Hearing Aids  | 10% coinsurance after deductible<br>up to the age of 24 <sup>1</sup>  | 30% coinsurance after deductible<br>up to the age of 24 <sup>2</sup>   |
| Chiropractic  | 10% coinsurance after deductible <sup>1</sup><br>30 <sup>6</sup> visits per plan year<br>Visit limits do not apply to the treatment of back pain    | 25% coinsurance after deductible <sup>2</sup><br>30 <sup>6</sup> visits per plan year<br>Visit limits do not apply to the treatment of back pain |

**Please note: Existing contracts and laws supersede any discrepancies with this brief benefits overview.**

<sup>1</sup> In-network benefits are subject to a plan year deductible of \$500 per person (\$1,000 per family). Two individuals must meet the deductible for the family deductible to be met. Benefits are then covered at the indicated percentage for that service until the total maximum out-of-pocket totals \$2,000 per person (\$4,000 per family). Two individuals must meet the total maximum out-of-pocket expense limit for benefits to be paid at 100% of the allowable charge for the rest of the family members.

<sup>2</sup> Out-of-network benefits are subject to a plan year deductible of \$1,000 per person (\$2,000 per family). Two individuals must meet the deductible for the family deductible to be met. Benefits are then covered at the indicated percentage for that service until the total maximum out-of-pocket totals \$4,000 per person (\$8,000 per family). Two individuals must meet the total maximum out-of-pocket expense limit for benefits to be paid at 100% of the allowable charge for the rest of the family members.

<sup>3</sup> Facility charges and professional services for bariatric surgery performed at a Blue Distinction Center for Bariatric Surgery (BDCBS) are covered at the in-network facility benefit level. For bariatric surgery performed at participating, but non-BDCBS facilities, all charges and services are subject to a 25% coinsurance, which does not accumulate toward any total maximum out-of-pocket expense limit. Members must meet eligibility criteria regardless of place of service.

<sup>4</sup> Facility charges and professional services for bariatric surgery performed at a non-participating facility are covered under the out-of-network benefit. All charges and services are subject to a 45% coinsurance which does not accumulate toward any total maximum out-of-pocket limit. Members must meet eligibility criteria regardless of place of service.

<sup>5</sup> Not subject to deductible.

<sup>6</sup> Your health plan benefit for chiropractic services includes visit limitations. The maximum number of visits allowed for a specific diagnosis is determined by medical necessity as provided to Highmark Delaware by your treating physician. In addition, services are limited to 30 days per plan year regardless of medical necessity except for visits for the purpose of treating back pain.

<sup>\*</sup> Prior authorization or precertification is required. The list of applicable services is subject to change.

<sup>\*\*</sup> Cost sharing is the responsibility of the member for any deductible or coinsurance.

<sup>\*\*\*</sup> To receive in-network benefits, be sure to use your designated lab facility. Lab facilities must be in-network with the referring provider's local Blue Cross Blue Shield plan to receive in-network benefits.

This plan is subject to certain limitations and exclusions. See your Benefit Booklet and Summary of Benefits and Coverage for details.

# Sample PPO Plan

This sample of benefits is intended to briefly highlight the health plans available. All percentages listed refer to Highmark Blue Cross Blue Shield Delaware's allowable charges.

| Description of Benefit  | In-Network Benefits  | Out-of-Network Benefits   |
|---|--|---|
| Deductibles – Plan Year   | None   | \$300 Individual, \$600 Family  |
| Total Maximum Out-of-Pocket Expense Limit Plan Year (includes copays and coinsurance) | \$4,500 Individual, \$9,000 Family   | \$7,500 Individual, \$15,000 Family   |
| Inpatient Room and Board*   | \$100 copay per day for first 2 days of admission then covered at 100%*  | 20% coinsurance after deductible <sup>1*</sup>                                    |
| Inpatient Physician and Surgeon Services  | 100% covered <sup>2</sup>  |   |
| Outpatient Surgery  | Ambulatory Center: \$50 copay per visit<br>Outpatient Dept. Hosp.: \$100 copay per visit   | 20% coinsurance after deductible <sup>1</sup>                                     |
| Bariatric Surgery   | See footnote <sup>2</sup>  | See footnote <sup>1,3</sup>   |
| Hospice   | 100% covered*  | 20% coinsurance after deductible <sup>1*</sup>                                    |
| Home Care Services  | 100% covered for up to 240 visits per plan year*   | 20% coinsurance after deductible for up to 240 visits per plan year <sup>1*</sup> |
| Emergency Services  | Facility: \$200 copay per visit, waived if admitted  | Facility: \$200 copay per visit, waived if admitted                               |
| Urgent Care Services  | \$20 copay per visit   | 20% coinsurance after deductible <sup>1</sup>                                     |
| Telemedicine Services (through Amwell or Doctor on Demand)                            | 100% covered   | Not covered   |
| <b>Mental Health Care/Substance Abuse Treatment</b>                                   |  |   |
| Inpatient Hospital Care and Partial/Intensive Outpatient Care                         | \$100 copay per day for the first 2 days per admission, then covered at 100% <sup>4</sup> (Partial/intensive outpatient care are not subject to the \$100 copay per visit) | 20% coinsurance after deductible <sup>1</sup>                                     |
| Outpatient Care   | \$20 copay per visit (mental health services performed by the telemedicine vendor, Amwell, are 100% covered)   | 20% coinsurance after deductible <sup>1</sup>                                     |

| Description of Benefit                               | In-Network Benefits  | Out-of-Network Benefits  |
|--|--|--|
| <b>Other Services</b>                                |  |  |
| Durable Medical Equipment                            | 100% covered   | 20% coinsurance after deductible <sup>1</sup>  |
| Skilled Nursing Facility                             | 100% covered for up to 120 days, renewable after 180 days without care*  | 20% coinsurance after deductible for up to 120 days, renewable after 180 days without care <sup>1*</sup>   |
| Emergency Ambulance                                  | 100% covered   | 100% covered   |
| Physician Home/Office Visits (sick)                  | \$20 copay per visit   | 20% coinsurance after deductible <sup>1</sup>  |
| Specialist Care                                      | \$30 copay per visit   |  |
| Allergy Testing and Allergy Treatment                | Testing: \$30 copay per visit<br>Treatment: \$5 copay per visit  |  |
| Lab*** and X-Ray                                     | Lab: \$10 copay per visit at Non-Hospital Affiliated Freestanding Facility/\$50 copay per visit at Hospital Affiliated Facility<br><br>X-Ray: 100% if done at a Non-Hospital Affiliated Freestanding Facility/\$50 copay per visit at Hospital Affiliated Facility |  |
| MRIs, MRAs, CTs, CTAs and PET Scans                  | 100% if done at a Non-Hospital Affiliated Freestanding Facility<br>\$75 copay per visit at Hospital Affiliated Facility (Prior auth. required)   | 20% coinsurance after deductible <sup>1</sup>  |
| Short-Term Therapies: Physical, Speech, Occupational | 15% coinsurance after deductible (The maximum number of visits allowed for a specific diagnosis is determined by medical necessity)  | 20% coinsurance after deductible (The maximum number of visits allowed for a specific diagnosis is determined by medical necessity) <sup>1</sup> |
| Annual Pap Smear and Gyn Exam                        | 100% covered   | 20% coinsurance after deductible <sup>1</sup>  |
| Periodic Physical Exams, Immunizations               | 100% covered   |  |
| Mammograms   | 100% covered   |  |
| Hearing Tests  | 100% covered   | 20% coinsurance after deductible <sup>1</sup>  |
| Hearing Aids   | 15% coinsurance after deductible up to the age of 24   | 20% coinsurance after deductible up to the age of 24 <sup>1</sup>  |
| Chiropractic   | 25% coinsurance after deductible<br>30 <sup>5</sup> visits per plan year<br>Visit limits do not apply to the treatment of back pain  | 45% coinsurance after deductible <sup>1</sup><br>30 <sup>5</sup> visits per plan year<br>Visit limits do not apply to the treatment of back pain |

**Please note: Existing contracts and laws supersede any discrepancies with this brief benefits overview.**

<sup>1</sup> Out-of-network benefits are subject to a plan year deductible of \$300 per person (\$600 per family). Two individuals must meet the deductible for the family deductible to be met. Benefits are then covered at the indicated percentage for that service until the total maximum out-of-pocket totals \$7,500 per person (\$15,000 per family). Two individuals must meet the total maximum out-of-pocket expense limit for benefits to be paid at 100% of the allowable charge for the rest of the family members.

<sup>2</sup> Facility charges and professional services for bariatric surgery performed at a Blue Distinction Center for Bariatric Surgery (BDCBS) are covered at the in-network facility benefit level. For bariatric surgery performed at participating, but non-BDCBS facilities, all charges and services are subject to a 25% coinsurance, which does not accumulate toward any total maximum out-of-pocket expense limit. Members must meet eligibility criteria regardless of place of service.

<sup>3</sup> Facility charges and professional services for bariatric surgery performed at a non-participating facility are covered under the out-of-network benefit. All charges and services are subject to a 45% coinsurance, which does not accumulate toward any total maximum out-of-pocket expense limit. Members must meet eligibility criteria regardless of place of service.

<sup>4</sup> In-network MH/SA benefit is for inpatient hospital care. Partial/intensive outpatient care is covered at 100%.

<sup>5</sup> Your health plan benefit for chiropractic services includes visit limitations. The maximum number of visits allowed for a specific diagnosis is determined by medical necessity as provided to Highmark Delaware by your treating physician. In addition, services are limited to 30 days per plan year regardless of medical necessity except for visits for the purpose of treating back pain.

\* Prior authorization or precertification is required. The list of applicable services is subject to change.

\*\* Cost-sharing is the responsibility of the member for any deductible or coinsurance.

\*\*\* To receive in-network benefits, be sure to use your designated lab facility. Lab facilities must be in-network with the referring provider's local Blue Cross Blue Shield plan to receive in-network benefits.

This plan is subject to certain limitations and exclusions. See your Benefit Booklet and Summary of Benefits and Coverage for details.



## Health care lingo, translated.

Phew, that's a lot of good stuff. And it just takes a tiny card with your name on it to get it all. Talk about simple.

When you're choosing a plan, you're bound to see certain terms over and over. Here's a cheat sheet for a few of the most important ones. (If you want the complete glossary, check your benefit booklet.)

### **PREMIUM**

The monthly amount you or your employer pay so you have health coverage.

### **DEDUCTIBLE**

The set amount you pay for covered health services before your plan starts paying.

### **COPAY**

The set amount you pay for a covered service. For example: \$20 for a doctor visit or \$30 for a specialist.

### **COINSURANCE**

The set amount you pay for a covered service after your deductible has been met. For example, if your plan pays 80%, you pay 20%.

### **ALLOWABLE CHARGES**

The set amount your plan will pay for a health service, even if your in-network provider bills for more.

### **IN-NETWORK PROVIDER**

A doctor, hospital, or health care provider that accepts your plan allowance and cost sharing as full payment. They won't bill you extra, but you could still have to pay your copays.

### **MAXIMUM OUT-OF-POCKET**

The most you'd pay for covered care. If you hit this amount, your plan pays 100% after that.



## Our friends in the legal department asked us to include this. Enjoy all the nitty gritty details.

\*There's a small handful of plans that aren't supported by My Care Navigator, but we're working on it.

Livongo® is a registered trademark of Livongo Health, Inc. Livongo is an independent company that provides a diabetes management program on behalf of Highmark.

Blues On Call is a service mark of the Blue Cross and Blue Shield Association.

Sharecare, RealAge Test and AskMD are registered trademarks of Sharecare, LLC., an independent and separate company that provides a consumer care engagement platform for Highmark members. Sharecare is solely responsible for its programs and services, which are not a substitute for professional medical advice, diagnosis or treatment. Sharecare does not endorse any specific product service or treatment. Health care plans and the benefits thereunder are subject to the terms of the applicable benefit agreement.

Amwell is a trademark of American Well Corporation and may not be used without written permission.

American Well is an independent company that provides telemedicine services and does not provide Blue Cross and/or Blue Shield products or services. American Well is solely responsible for their telemedicine services.

My Care Navigator is a service mark of Highmark Inc.

Blue Distinction Specialty Care is a registered mark of the Blue Cross Blue Shield Association. Blue Distinction Centers (BDC) met overall quality measures, developed with input from the medical community. A Local Blue Plan may require additional criteria for providers located in its own service area; for details, contact your Local Blue Plan. Blue Distinction Centers+ (BDC+) also met cost measures that address consumers' need for affordable healthcare. Each provider's cost of care is evaluated using data from its Local Blue Plan. Providers in CA, ID, NY, PA, and WA may lie in two Local Blue Plans' areas, resulting in two evaluations for cost of care; and their own Local Blue Plans decide whether one or both cost of care evaluation(s) must meet BDC+ national criteria. Total Care ("Total Care") providers have met national criteria based on provider commitment to deliver value-based care to a population of Blue members. Total Care+ providers also met a goal of delivering quality care at a lower total cost relative to other providers in their area. Program details are displayed on [www.bcbs.com](http://www.bcbs.com). Individual outcomes may vary. For details on a provider's in-network status or your own policy's coverage, contact your Local Blue Plan and ask your provider before making an appointment.

Neither Blue Cross and Blue Shield Association nor any Blue Plans are responsible for noncovered charges or other losses or damages resulting from Blue Distinction, Total Care, or other provider finder information or care received from Blue Distinction, Total Care, or other providers.

Highmark Blue Cross Blue Shield Delaware is an independent licensee of the Blue Cross and Blue Shield Association. Blue 365, Blue Distinction® Specialty Care, Blue Distinction Centers, BlueCard®, Blue Cross, Blue Shield and the Cross and Shield symbols are registered service marks of the Blue Cross and Blue Shield Association.

All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration.

### Discrimination is Against the Law

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Claims Administrator/Insurer will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Claims Administrator/Insurer will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Claims Administrator/Insurer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: [CivilRightsCoordinator@highmarkhealth.org](mailto:CivilRightsCoordinator@highmarkhealth.org). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

If you speak English, language assistance services, free of charge, are available to you. Call 1-800-876-7639.

Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al 1-800-876-7639.

如果您说中文，可向您提供免费语言协助服务。請致電 1-800-876-7639。

Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số 1-800-876-7639.

한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. 1-800-876-7639 로 전화.

Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyonang tulong sa wika. Tumawag sa 1-800-876-7639.

Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Звоните 1-800-876-7639.

إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل على الرقم 1-800-876-7639 .

Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan 1-800-876-7639.

Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez au 1-800-876-7639.

Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń 1-800-876-7639.

Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para 1-800-876-7639.

Se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Chiamare l'1-800-876-7639.

Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie 1-800-876-7639.

日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。 1-800-876-7639 を呼び出します。

اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان رایگان با تماس با شماره 1-800-876-7639 .





Because Life.™

**Sample Guide 2023-2024**

03/23 MX2316256