



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to [Wellfleet Student - University of California Berkeley](#) or call Member Services at 1-877-657-5033. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-877-657-5033 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$450/Individual or \$1,350/Family In- <a href="#">Network Provider</a> / <a href="#">Out-of-Network Provider</a> combined	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. Pediatric Vision; Pediatric Preventive Dental; <a href="#">Prescription Drugs</a> ; In- <a href="#">Network Provider</a> Preventive care; In- <a href="#">Network Provider</a> Primary Care/ <a href="#">Specialist</a> Visits; In- <a href="#">Network Provider</a> Rehabilitation/Habilitation; <a href="#">Urgent Care</a> ; Emergency Services; Ambulance Services; Community Based CARE Program; and services rendered at the Student Health Center (SHC) are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	Yes. \$60/Individual or \$180/Family for Pediatric Dental In- <a href="#">Network Provider</a> / <a href="#">Out-of-Network Provider</a> combined. There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	\$5,000/Individual or \$10,000/Family In- <a href="#">Network Provider</a> and \$10,000/Individual or \$20,000/Family <a href="#">Out-of-Network Provider</a> ; and for Pediatric Dental, \$1,000/Individual or \$2,000/Family In- <a href="#">Network Provider</a> / <a href="#">Out-of-Network Provider</a> combined. The combined <a href="#">out-of-pocket limit</a> will never exceed the maximum amount permitted by law.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.wellfleetstudent.com/ucbprovidersearch">www.wellfleetstudent.com/ucbprovidersearch</a> or call 877-657-5033 for a list of In- <a href="#">Network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$15 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	-None-
	<a href="#">Specialist</a> visit	\$25 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	When requested and approved by the attending physician.
	<a href="#">Preventive care/screening/immunization</a>	No charge	50% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Pre-Certification required for certain services. See certificate for details regarding Pre-Certification.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Pre-Certification required for certain services. See certificate for details regarding Pre-Certification.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p><b>If you need drugs to treat your illness or condition</b> More information about <a href="https://uhs.berkeley.edu/insurance/ship-benefits/prescriptions">prescription drug coverage</a> is available at <a href="https://uhs.berkeley.edu/insurance/ship-benefits/prescriptions">https://uhs.berkeley.edu/insurance/ship-benefits/prescriptions</a></p>	Tier 1 (Generic drugs)	\$20 <a href="#">copay</a> /prescription; (\$10 <a href="#">copay</a> /prescription at SHC); <a href="#">deductible</a> does not apply	\$20 <a href="#">copay</a> /prescription then 50% <a href="#">coinsurance</a> up to \$250 <a href="#">copay</a> /prescription plus all charges in excess of the In- <a href="#">Network</a> prescription drug maximum negotiated charge; <a href="#">deductible</a> does not apply	<p>Your benefit is limited to a 30 day supply. For package sizes that exceed a 30-day supply, see the “Retail Pharmacy Supply Limits” section in the Certificate.</p> <p>No <a href="#">cost sharing</a> applies to Affordable Care Act (ACA) <a href="#">Preventive Care</a> medications filled at a participating In-<a href="#">Network</a> pharmacy.</p> <p><a href="#">Out-of-Network provider</a> benefits are provided on a reimbursement basis. <a href="#">Claim</a> forms must be submitted to us as soon as reasonably possible.</p>
	Tier 2 (Preferred brand drugs)	\$40 <a href="#">copay</a> /prescription; (\$25 <a href="#">copay</a> /prescription at SHC); <a href="#">deductible</a> does not apply	\$40 <a href="#">copay</a> /prescription then 50% <a href="#">coinsurance</a> up to \$250 <a href="#">copay</a> /prescription plus all charges in excess of the In- <a href="#">Network</a> prescription drug maximum negotiated charge; <a href="#">deductible</a> does not apply	
	Tier 3 (Non-preferred brand drugs)	\$60 <a href="#">copay</a> /prescription; (\$40 <a href="#">copay</a> /prescription at SHC); <a href="#">deductible</a> does not apply	\$60 <a href="#">copay</a> /prescription then 50% <a href="#">coinsurance</a> up to \$250 <a href="#">copay</a> /prescription plus all charges in excess of the In- <a href="#">Network</a> prescription drug maximum negotiated charge; <a href="#">deductible</a> does not apply	
	<a href="#">Specialty drugs</a>	20% <a href="#">coinsurance</a> up to \$250 max/prescription; (\$75 <a href="#">copay</a> /prescription at SHC); <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a> up to \$250 <a href="#">copay</a> /prescription plus all charges in excess of the In- <a href="#">Network</a> prescription drug maximum negotiated charge; <a href="#">deductible</a> does not apply	
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Pre-Certification required. See certificate for details.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Pre-Certification required. See certificate for details.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$250 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	\$250 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	Benefits will be payable for services received in a hospital emergency department or independent freestanding emergency department. <a href="#">Copayment</a> waived if admitted.
	<a href="#">Emergency medical transportation</a>	For Mental Health Disorders and Substance Use Disorders: No Charge  For other than Mental Health Disorders or Substance Use Disorders: 20% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	For Mental Health Disorders and Substance Use Disorders: No Charge  For other than Mental Health Disorders or Substance Use Disorders: 20% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	Including ground and/or air, water transportation. Pre-Certification required for non-emergency air ambulance (fixed wing). See certificate for details.
	<a href="#">Urgent care</a>	\$50 <a href="#">copay</a> /visit (\$35 <a href="#">copay</a> /visit then 20% <a href="#">coinsurance</a> for any ancillary services at SHC); <a href="#">deductible</a> does not apply	\$50 <a href="#">copay</a> /visit ; <a href="#">deductible</a> does not apply	Treatment for non-life-threatening conditions.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$250 <a href="#">copay</a> /admission then 20% <a href="#">coinsurance</a>	\$500 <a href="#">copay</a> /admission then 50% <a href="#">coinsurance</a>	Pre-Certification required. See certificate for details.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Pre-Certification required for inpatient surgery. See certificate for details.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Office Visits: \$15 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply  All Other Outpatient Services: 20% <a href="#">coinsurance</a>  Community Based Care Program (CARE): No charge  Mobile Crisis Services/988 Center: 20% <a href="#">coinsurance</a>	Office Visits: 50% <a href="#">coinsurance</a>  All Other Outpatient Services: 50% <a href="#">coinsurance</a>  Community Based Care Program (CARE): No charge  Mobile Crisis Services/988 Center: 20% <a href="#">coinsurance</a>	Office Visits including but not limited to physician visits, individual and group therapy, hormone therapy, medication management  All Other Outpatient Services including but not limited to: Intensive Outpatient Programs; Partial Hospitalization, Electronic Convulsive Therapy, Repetitive Transcranial Magnetic Stimulation (rTMS); Psychiatric and Neuro Psychiatric testing; and Gender Affirming Treatment including reassignment surgery.  Pre-Certification required for surgery. See certificate for details.
	Inpatient services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Pre-Certification required for surgery. See certificate for details.
<b>If you are pregnant</b>	Office visits	\$15 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	No charge/prenatal, including ultrasounds, and 1 <sup>st</sup> postnatal visits.  <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC.
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	\$250 <a href="#">copay</a> /admission then 20% <a href="#">coinsurance</a>	\$500 <a href="#">copay</a> /admission then 50% <a href="#">coinsurance</a>	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Limited to 100 visits/policy year. Separate limits apply to <a href="#">Rehabilitation Services</a> and <a href="#">Habilitation Services</a> . Pre-Certification required. See certificate for details.
	<a href="#">Rehabilitation services</a>	\$15 <a href="#">copay</a> /visit; deductible does not apply	50% <a href="#">coinsurance</a>	Includes Cardiac, Pulmonary, Physical, Occupational, and Speech Therapies. Pre-Certification required. See certificate for details.
	<a href="#">Habilitation services</a>	\$15 <a href="#">copay</a> /visit; deductible does not apply	50% <a href="#">coinsurance</a>	Includes Cardiac, Pulmonary, Physical, Occupational, and Speech Therapies. Pre-Certification required. See certificate for details.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<a href="#">Skilled nursing care</a>	\$250 <a href="#">copay</a> /admission then 20% <a href="#">coinsurance</a>	\$500 <a href="#">copay</a> /admission then 50% <a href="#">coinsurance</a>	Limited to 100 days/benefit period. This limit does not apply to mental health, behavioral health, or substance abuse services. Pre-Certification required. See certificate for details.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Pre-Certification required. See certificate for details.
	<a href="#">Hospice services</a>	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	-None-
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	No charge	To the end of the month when the Insured Person turns age 19. Limited to 1 visit/policy year.
	Children's glasses	No charge	No charge	To the end of the month when the Insured Person turns age 19. Limited to 1 pair eyeglasses or contact lenses in lieu of eyeglasses/policy year.
	Children's dental check-up	No charge	No charge	For Preventive Dental Care. To the end of the month when the Insured Person turns age 19. Limited to 1 exam/6-month period. Deductible does not apply to pediatric diagnostic/preventive care.

### Excluded Services & Other Covered Services:

**Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)**

- |  |  |  |
|--|--|--|
| <ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• Infertility treatment</li> </ul> | <ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Private-duty nursing</li> <li>• Routine eye care (Adult)</li> </ul> | <ul style="list-style-type: none"> <li>• Weight loss programs</li> </ul> |
|--|--|--|

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

- |  |   |   |
|--|---|---|
| <ul style="list-style-type: none"> <li>• Acupuncture (Pre-Certification required)</li> <li>• Bariatric surgery (Pre-Certification required)</li> <li>• Chiropractic care (Pre-Certification required)</li> </ul> | <ul style="list-style-type: none"> <li>• Hearing aids (1 aid/ear every 3 years; Pre-Certification required)</li> <li>• Most non-emergency care when traveling outside the U.S. (See certificate for details)</li> </ul> | <ul style="list-style-type: none"> <li>• Routine foot care (medically necessary)</li> </ul> |
|--|---|---|

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: <http://www.insurance.ca.gov/> or contact Wellfleet Insurance Company toll free 877-657-5033. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318- 2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: <http://www.insurance.ca.gov/> or California Department of Insurance, 300 S. Spring Street, 11<sup>th</sup> Floor, Los Angeles, CA 90013, Inside State Toll-Free:1-800-927-4357, Outside State:1-213-897-8921, TDD:1-800-482-4833.

**Does this plan provide Minimum Essential Coverage? Yes**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this plan meet the Minimum Value Standards? Not Applicable.**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al (877) 657-5033.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (877) 657-5033.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 (877) 657-5033.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (877) 657-5033.

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*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$450
■ <a href="#">Specialist copayment</a>	\$25
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$450
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,310</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$450
■ <a href="#">Specialist copayment</a>	\$25
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$450
<a href="#">Copayments</a>	\$800
<a href="#">Coinsurance</a>	\$90
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,360</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$450
■ <a href="#">Specialist copayment</a>	\$25
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$450
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$80
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$930</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

## NOTICE OF NON-DISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

The Company 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 Company does not exclude people or treat them worse because of their race, color, national origin, age, disability, or sex.

The Company provides free aids and services to people with disabilities to communicate effectively with us, such as:

1. Qualified sign language interpreters
2. Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose first language is not English when needed to communicate effectively with us, such as:

1. Interpreters
2. information translated into other languages

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

If you believe that Wellfleet Insurance Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator,  
PO Box 15369, Springfield, MA 01115-5369  
(413)-733-4540  
[civilcoordinator@wellfleetinsurance.com](mailto:civilcoordinator@wellfleetinsurance.com)

You can file a grievance in person, by mail, fax, or email. If you need help filing a grievance Our 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, DC 20201  
800-868-1019; 800-537-7697 (TDD)

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

The Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

## LANGUAGE ASSISTANCE PROGRAM

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call (877) 657-5030.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al (877) 657-5030.

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請致電：(877) 657-5030。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi (877) 657-5030.

알림: 한국어(**Korean**)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다.

(877) 657-5030번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa (877) 657-5030.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по номеру (877) 657-5030.

مہینتہ: اذانتک شذحتتہ **تیبیرعلا (Arabic)**، نإفاتامدخد ددعاسملا تیوغللا تیناجملا تحتامکلا. عاجرلا لاصتلاً ب (877) 657-5030.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan (877) 657-5030.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le (877) 657-5030.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer (877) 657-5030.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para (877) 657-5030.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero (877) 657-5030.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie (877) 657-5030 an.

注意事項：日本語(Japanese) を話される場合、無料の言語支援サービスをご利用いただけます。(877) 657-5030 にお電話ください。

ی سراف امشد نابز رگا :هجوت (Farsi) دشادی مامشدرایتخا رد ناگیار روط هب ی نابز دادما تامدخ ،تسا .  
تمس یا بیگرید. (877) 657-5030

कृपा ध्या दाः याद आप [हंद] (Hindi) भाषी ह तो आपके [लए भाषा सहायता सेवाएं]नःशुल् उपलब् ह। कृपा पर काल कर। (877) 657-5030

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau (877) 657-5030.

ប្រយ័ត្ន: ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ (Khmer) សេវាកម្មភាសាជំនួយឥតគិតថ្លៃមានសម្រាប់អ្នក។ សូមទូរស័ព្ទមកលេខ (877) 657-5030 ។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti (877) 657-5030.

Díí BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yánilti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjí' (877) 657-5030 hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac (877) 657-5030

ગુજરાતી (Gujarati) યુ ના: જો તમે જરાતી બોલતા છે, તો િન:લુ ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છે. ફોન કરો (877) 657-5030

λληνικά (Greek)ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε (877) 657-5030

Українська (Ukrainian) УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером (877) 657-5030

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በገጻ ሊያግዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደው(877) 657-5030

ਪੰਜਾਬੀ (Punjabi) ਧਆਨ ਿਦਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਭਾਸ਼ਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ (877) 657-5030

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ (877) 657-5030