

Your summary of benefits

Anthem BlueCross and BlueShield

Your Contract Code: 3J4U

Your Plan: Anthem Gold Blue Open Access POS 2500/0%/5000

Your Network: Blue Open Access POS

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. 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 formal Evidence of Coverage (EOC). If there is a difference between this summary and the Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or Evidence of Coverage (EOC), will prevail.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible <i>See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.</i>	\$2,500 person / \$7,500 family	\$7,500 person / \$22,500 family
Out-of-Pocket Limit <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. See notes section for additional information regarding your out of pocket maximum.</i>	\$5,000 person / \$10,000 family	\$15,000 person / \$45,000 family
Preventive care/screening/immunization <i>In-network preventive care is not subject to deductible, if your plan has a deductible. Non-Network preventive care services for children prior to their 6th birthday have no deductible.</i>	No charge	30% coinsurance after deductible is met
Doctor Home and Office Services Primary Care Office Visit to treat an injury or illness	\$30 copay per visit deductible does not apply	30% coinsurance after deductible is met
Specialist Care Office Visit	\$60 copay per visit deductible does not apply	30% coinsurance after deductible is met

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prenatal and Post-natal Care	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Other Practitioner Visits: Retail Health Clinic On-line Visit <i>Live Health Online is the preferred telehealth solutions (www.livehealthonline.com)</i> Manipulation Therapy <i>Coverage is limited to 20 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.</i> Acupuncture	\$30 copay per visit deductible does not apply No charge for the first 12 visits and then \$30 copay per visit deductible does not apply \$30 copay per visit deductible does not apply Not covered	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met Not covered
Other Services in an Office: Allergy Testing Chemo/Radiation Therapy Hemodialysis Prescription Drugs <i>For the drugs itself dispensed in the office through infusion/injection.</i>	\$30 copay per visit deductible does not apply 0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met
Diagnostic Services Lab:		

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Office <i>Office Cost Share applies only when Freestanding/Reference Labs are not used.</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Lab/Reference Lab	No charge	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
X-Ray:		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Radiology Center	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Radiology Center	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Emergency and Urgent Care		

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Urgent Care (Office Setting)	\$100 copay per visit deductible does not apply	30% coinsurance after deductible is met
Emergency Room Facility Services <i>Copay waived if admitted.</i>	\$300 copay per visit and 0% coinsurance deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	0% coinsurance after deductible is met	Covered as In-Network
Ambulance (Air and Ground)	0% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder		
Doctor Office Visit and Online Visit	\$30 copay per visit deductible does not apply	30% coinsurance after deductible is met
Facility visit:		
Facility Fees	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor Services	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees:		
Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Surgical Center	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor and Other Services:		

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Surgical Center	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Hospital Stay (all Inpatient stays including Maternity, Mental and Substance Use Disorder): Facility fees (for example, room & board) <i>Coverage for Inpatient rehabilitation and skilled nursing services combined In-Network Providers and Non-Network Providers combined is limited to 60 days per benefit year.</i> Doctor and other services	0% coinsurance after deductible is met 0% coinsurance after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met
Recovery & Rehabilitation Home Care Visits <i>Coverage for In-Network Providers and Non-Network Providers combined is limited to 120 visits per benefit period. Visit limit does not apply to Physical, Occupational or Speech Therapy when performed as part of Home Health.</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy): Office <i>Coverage for physical therapy and occupational therapy combined is limited to 20 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Apply to In-Network Providers and Non-Network Providers combined. Visit limits are combined both across outpatient and other professional visits.</i> Outpatient Hospital <i>Coverage for physical therapy and occupational therapy combined is limited to 20 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Apply to In-Network Providers and Non-Network Providers combined. Visit limits are combined both across outpatient and other professional visits.</i>	\$30 copay per visit deductible does not apply 0% coinsurance after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Habilitation services (for example, physical/speech/occupational therapy): Office <i>Coverage for physical therapy and occupational therapy combined is limited to 20 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Apply to In-Network Providers and Non-Network Providers combined. Visit limits are combined both across outpatient and other professional visits.</i> Outpatient Hospital <i>Coverage for physical therapy and occupational therapy combined is limited to 20 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Apply to In-Network Providers and Non-Network Providers combined. Visit limits are combined both across outpatient and other professional visits.</i>	 \$30 copay per visit deductible does not apply 0% coinsurance after deductible is met	 30% coinsurance after deductible is met 30% coinsurance after deductible is met
Cardiac rehabilitation Office Outpatient Hospital	 \$60 copay per visit deductible does not apply 0% coinsurance after deductible is met	 30% coinsurance after deductible is met 30% coinsurance after deductible is met
Skilled Nursing Care (in a facility) <i>Coverage for Inpatient rehabilitation and skilled nursing services combined In-Network Providers and Non-Network Providers combined is limited to 60 days per benefit period.</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Hospice	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Durable Medical Equipment <i>Coverage for hearing aids services left ear is limited to 1 unit every 48 months and right ear is limited to 1 unit every 48 months for children 18 years of age or under. Coverage is limited to \$3,000 per hearing aid. Apply to In-Network Providers and Non-Network Providers combined.</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prosthetic Devices <i>Coverage for wigs needed after cancer treatment In-Network Providers and Non-Network Providers combined is limited to 1 items per benefit period.</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Not Applicable	Not Applicable	Not Applicable
Pharmacy Out of Pocket	Combined with In-Network medical out of pocket maximum	Combined with medical out of pocket maximum	Combined with medical out of pocket maximum
Prescription Drug Coverage <i>Select Drug List</i> <i>This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies.</i>			
Tier 1a - Typically Lower Cost Generic <i>Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.</i>	\$5 copay per Prescription deductible does not apply (retail only). \$13 copay per Prescription deductible does not apply (home delivery only).	\$15 copay per Prescription deductible does not apply (retail only).	30% coinsurance deductible does not apply (retail only).
Tier 1b - Typically Generic <i>Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.</i>	\$20 copay per Prescription deductible does not apply (retail only). \$50 copay per Prescription deductible does not apply (home delivery only).	\$30 copay per Prescription deductible does not apply (retail only).	30% coinsurance deductible does not apply (retail only).
Tier 2 – Typically Preferred Brand <i>Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.</i>	\$50 copay per Prescription deductible does not apply (retail only). \$150 copay per Prescription deductible does not	\$60 copay per Prescription deductible does not apply (retail only).	30% coinsurance deductible does not apply (retail only).

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
	apply (home delivery only).		
Tier 3 - Typically Non-Preferred Brand <i>Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.</i>	\$90 copay per Prescription deductible does not apply (retail only). \$270 copay per Prescription deductible does not apply (home delivery only).	\$100 copay per Prescription deductible does not apply (retail only).	30% coinsurance deductible does not apply (retail only).
Tier 4 - Typically Specialty (brand and generic) <i>Covers up to a 30 day supply (retail pharmacy). Covers up to a 30 day supply (home delivery program). No coverage for non-formulary drugs.</i>	20% coinsurance deductible does not apply (retail and home delivery).	20% coinsurance deductible does not apply (retail only).	30% coinsurance deductible does not apply (retail only).

Your summary of benefits

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-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.</i></p>		
Children's Vision Essential Health Benefits (up to age 19) Child Vision Deductible Vision exam <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period.</i>	\$0 person No charge	Not Applicable Reimbursed Up to \$30
Frames <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.</i>	No charge	Reimbursed Up to \$45
Lenses <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.</i>	No charge	\$25 Reimbursement for Single, \$40 Reimbursement for Bifocal and \$55 Reimbursement for Trifocal Vision Lens
Elective contact lenses <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.</i>	No charge	Reimbursed Up to \$60
Non-Elective Contact Lenses <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.</i>	No charge	Reimbursed Up to \$210
Adult Vision (age 19 and older) Adult Vision Deductible Vision exam <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period.</i>	\$0 person \$20 copay	Not Applicable Reimbursed Up to \$30
Frames	Not covered	Not covered

Your summary of benefits

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Lenses	Not covered	Not covered
Elective contact lenses	Not covered	Not covered
Non-Elective Contact Lenses	Not covered	Not covered

Your summary of benefits

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-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.</i></p> <p><i>Only children's dental services count towards your out of pocket limit.</i></p>		
Children's Dental Essential Health Benefits Diagnostic and preventive <i>Coverage for In-Network Providers and Non-Network Providers combined is limited to 2 visits per benefit period.</i>	10% coinsurance deductible does not apply	10% coinsurance deductible does not apply
Basic services	40% coinsurance after deductible is met	40% coinsurance after deductible is met
Major services	40% coinsurance after deductible is met	40% coinsurance after deductible is met
Medically Necessary Orthodontia services	40% coinsurance after deductible is met	40% coinsurance after deductible is met
Cosmetic Orthodontia services	Not covered	Not covered
Deductible	Combined with medical deductible	Combined with medical deductible
Adult Dental		
Diagnostic and preventive	Not covered	Not covered
Basic services	Not covered	Not covered
Major services	Not covered	Not covered
Deductible	Not Applicable	Not Applicable

Your summary of benefits

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Annual maximum	Not covered	Not covered

Your summary of benefits

Your plan also includes the following Reward features.

To see your rewards and additional information log into the Anthem website at 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.

Health Assessment	This tool helps you understand your current health opportunities and identify changes you can make to improve your health. Subscriber and spouse/domestic partner may be eligible to earn a reward for completing the health assessment each year. In some cases, this activity may require the completion of the Tobacco Certification Program in order to earn the rewards.	Up to \$50 per member per year.
Processed Claim: Annual Flu Shot	Subscriber and spouse/domestic partner may earn a reward if you get your annual flu shot and it is verified by an Anthem claim. This activity requires completion of the Adult Wellness Exam in order to earn the rewards.	Up to \$50 per member per year.
Processed Claim: Adult Wellness Exam	Subscriber and spouse/domestic partner may earn a reward if you complete an annual preventive wellness exam and it is verified by an Anthem claim. This activity requires completion of the Annual Flu Shot in order to earn the rewards.	Up to \$50 per member per year.
Tobacco Certification Program	Subscriber and spouse/domestic partner may earn a reward when you confirm you're tobacco free. It will be only for the current year of your employer's program; you will need to confirm this each year to receive your reward. In some cases, this activity may require the completion of the Health Assessment in order to earn the rewards.	Up to \$50 per member per year.

Your summary of benefits

Notes:

- For additional information on this plan, please visit www.sbc.anthem.com to obtain a "Summary of Benefit Coverage."
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- If readmitted within 72 hours for the same diagnosis of the previous discharge, no additional facility copayment is required. If transferred between facilities, only one copayment will apply.
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- If your plan includes out of network benefits and you use a non-participating provider, you are responsible for any difference between the covered expense and the actual non-participating providers charge.
- The family deductible and out-of-pocket maximum are embedded indicating the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; additionally, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.
- All medical and pharmacy deductibles, copayments and coinsurance apply to the out of pocket maximum.
- Physical Therapy: Athletic Trainers are covered by mandate for out-of-network only since athletic trainers are not contracted nor credentialed, therefore are not "in-network".
- Home Delivery Choice for Maintenance Drugs - You may get the first 30 day supply and up to one more 30 day refill of the same Maintenance Medication at a retail pharmacy. Prior to the 3rd refill, you must contact us at 888-772-5188 or at www.anthem.com and tell us if you would like to keep getting your Maintenance Medications from the retail pharmacy or if you would like Home Delivery. If you do not contact us, you will pay the full retail cost of any Maintenance Medication until you inform us of your decision.
- Level 1 Pharmacies include, but are not limited to, CVS, Target, Walmart, Kroger, Safeway, Costco, Ingles and Fred's. Level 2 Pharmacies include, but are not limited to, Publix, Rite Aid and Walgreens. For a complete list of Level 1 and Level 2 pharmacies, you can go to www.anthem.com/pharmacyinformation and select Rx Networks and then Rx Choice Tiered Network pharmacies.
- Covered out-of-network Human Organ and Tissue Transplant services do not apply toward the out-of-pocket limit

Your summary of benefits

Anthem Blue Cross and Blue Shield is the trade name of Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. Independent licensee of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc.

Questions: (855) 837-8541 or visit us at www.anthem.com

GA/SG/Anthem Gold Blue Open Access POS 2500/0%/5000/3J4U/01-01-2019

Language Access Services:

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:

If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (855) 837-8541

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

(TTY/TDD: 711)

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (855) 837-8541.

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (855) 837-8541:

Chinese(中文): 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(855) 837-8541。

Farsi (فارسی): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادریتان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (855) 837-8541 تماس بگیرید.

French (Français): Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (855) 837-8541.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (855) 837-8541.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (855) 837-8541.

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(855) 837-8541 にお電話ください。

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(855) 837-8541로 문의하십시오.

Navajo (Diné): Dii naaltsoos biká'ígíí lahgo bina'idílkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehj bee níl hodoonih t'áadoo bááh ilínígóó. Ata' halne'ígíí la' bich'i' hadeesdzih nínizingo kojí' hodiilnih (855) 837-8541.

Language Access Services:

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer: (855) 837-8541.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (855) 837-8541 ਤੇ ਕਾਲ ਕਰੋ।

Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (855) 837-8541.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (855) 837-8541.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (855) 837-8541.

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (855) 837-8541.

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.