

Your summary of benefits



Anthem. HealthKeepers

Anthem® HealthKeepers Inc.

Your Contract Code: 5L87

Your Plan: Anthem HealthKeepers Gold OAPOS 25/20%/6000

Your Network: HealthKeepers

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This policy has exclusions and limitations to benefits and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, contact your insurance agent or contact us. If there is a difference between this summary and the contract of coverage, the contract of coverage will prevail.

This benefit summary is not to be distributed without also providing access to the applicable Anthem HealthKeepers enrollment brochure.

| 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> | \$0 person / \$0 family | \$2,000 person / \$4,000 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> | \$6,000 person / \$12,000 family | \$15,000 person / \$30,000 family |
| Preventive care/screening/immunization <i>In-network preventive care is not subject to deductible, if your plan has a deductible.</i> | No charge | 50% coinsurance after deductible is met |
| Doctor Home and Office Services | | |
| Primary Care Office Visit to treat an injury or illness | \$25 copay per visit | 50% coinsurance after deductible is met |
| Enhanced Personal Healthcare Provider Office Visit | \$15 copay per visit | Not Applicable |

Your summary of benefits

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|--|--|---|
| Specialist Care Office Visit and Online Visit | \$60 copay per visit | 50% coinsurance after deductible is met |
| Prenatal and Post-natal Care <i>In-Network preventive prenatal services are covered at 100%.</i> | \$350 copay per pregnancy | 50% coinsurance after deductible is met |
| Other Practitioner Visits: | | |
| Retail Health Clinic | \$25 copay per visit | 50% coinsurance after deductible is met |
| Preferred On-line Visit <i>Includes Mental Health and Substance Use Disorder Live Health Online is the preferred telehealth solution. (www.livehealthonline.com).</i> | \$10 copay per visit | 50% coinsurance after deductible is met |
| Other Participating Provider On-line Visit <i>Includes Mental Health and Substance Use Disorder</i> | \$25 copay per visit | 50% coinsurance after deductible is met |
| Chiropractic Services <i>Coverage for Rehabilitation and Habilitation is limited to 30 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.</i> | \$25 copay per visit | 50% coinsurance after deductible is met |
| Acupuncture | Not covered | Not covered |
| Other Services in an Office: | | |
| Allergy Testing | \$15 copay per visit | 50% coinsurance after deductible is met |
| Radiation/Chemotherapy/Non Preventive Infusion & Injection | 20% coinsurance | 50% coinsurance after deductible is met |
| Hemodialysis | 20% coinsurance | 50% 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 |
|---|---|---|
| Prescription Drugs <i>For the drugs itself dispensed in the office through infusion/injection.</i> | 20% coinsurance | 50% coinsurance after deductible is met |
| Diagnostic Services Lab: Office Preferred Reference Lab Outpatient Hospital | 20% coinsurance No charge \$60 copay per visit | 50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met |
| X-Ray: Office Freestanding Radiology Center Outpatient Hospital | 20% coinsurance \$60 copay per visit \$60 copay per visit | 50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met |
| Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans): Office Freestanding Radiology Center | \$60 copay per service \$100 copay per service | 50% coinsurance after deductible is met 50% 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 |
|---|--|---|
| Outpatient Hospital | \$200 copay per service | 50% coinsurance after deductible is met |
| Emergency and Urgent Care Urgent Care Center Office Visit | \$60 copay per visit | 50% coinsurance after deductible is met |
| Emergency Room Facility Services <i>Copay waived if admitted.</i> | \$400 copay per visit | Covered as In-Network |
| Emergency Room Doctor and Other Services | 20% coinsurance | Covered as In-Network |
| Emergency Room Mental Health and Substance Use Disorder Doctor Services | \$25 copay per visit | Covered as In-Network |
| Ambulance Transportation | 20% coinsurance | Covered as In-Network |
| Outpatient Mental Health and Substance Use Disorder Doctor Office Visit | \$25 copay per visit | 50% coinsurance after deductible is met |
| Facility visit: Facility Fees | \$350 copay per visit | 50% coinsurance after deductible is met |
| Doctor Services | \$25 copay per visit | 50% 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 |
|---|--|---|
| <p>Outpatient Surgery</p> <p>Facility Fees:</p> <p>Hospital</p> <p>Freestanding Surgical Center</p> <p>Doctor and Other Services:</p> <p>Hospital</p> <p>Freestanding Surgical Center</p> | <p>\$350 copay per visit</p> <p>\$250 copay per visit</p> <p>20% coinsurance</p> <p>\$60 copay per visit</p> | <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> |
| <p>Hospital Stay (all Inpatient stays including Maternity, Mental and Substance Use Disorder):</p> <p>Facility fees (for example, room & board) <i>Coverage for Inpatient Rehabilitation and Skilled Nursing services is limited to 100 days combined per admission. Limit is combined In-Network and Non-Network.</i></p> <p>Doctor and other services</p> | <p>\$500 copay per day to a maximum of \$2,000 per admission</p> <p>20% coinsurance</p> | <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> |

Your summary of benefits

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|--|---|
| <p>Recovery & Rehabilitation</p> <p>Home Health Care <i>Coverage is limited to 100 visits per benefit period. Private Duty Nursing included with Home Health Care is limited to 16 hours per benefit period. Limit is combined In-Network and Non-Network. Visit limit does not apply to Home Infusion Therapy or Home Dialysis.</i></p> | 20% coinsurance | 50% coinsurance after deductible is met |
| <p>Rehabilitation services (for example, physical/speech/occupational therapy):</p> <p>Office <i>Coverage for Physical Therapy and Occupational Therapy is limited to 30 visits combined per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings. Coverage for Speech Therapy is limited to 30 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings. Benefit limit does not apply to Applied Behavioral Analysis. Visit limit does not apply when performed as part of Early Intervention or Hospice. When rendered in the home, the Home Care visit limit applies instead of the Therapy Services limits.</i></p> <p>Outpatient Hospital <i>Coverage for Physical Therapy and Occupational Therapy is limited to 30 visits combined per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings. Coverage for Speech Therapy is limited to 30 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings. Visit limit does not apply when performed as part of Early Intervention or Hospice. When rendered in the home, the Home Care visit limit applies instead of the Therapy Services limits. Benefit limit does not apply to Applied Behavioral Analysis.</i></p> | \$25 copay per visit | 50% coinsurance after deductible is met |
| <p>Habilitation services (for example, physical/speech/occupational therapy):</p> <p>Office <i>Coverage for Physical Therapy and Occupational Therapy is limited to 30 visits combined per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings. Coverage for Speech Therapy is limited to 30 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings. Benefit limit does not apply to Applied Behavioral Analysis.</i></p> | \$25 copay per visit | 50% 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 |
|--|---|---|
| <p>Outpatient Hospital <i>Coverage for Physical Therapy and Occupational Therapy is limited to 30 visits combined per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings. Coverage for Speech Therapy is limited to 30 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings. Benefit limit does not apply to Applied Behavioral Analysis.</i></p> | \$60 copay per visit | 50% coinsurance after deductible is met |
| <p>Cardiac rehabilitation</p> <p>Office Visit</p> <p>Outpatient Hospital</p> | <p>\$60 copay per visit</p> <p>20% coinsurance</p> | <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> |
| <p>Skilled Nursing Care (in a facility) <i>Coverage for Inpatient Rehabilitation and Skilled Nursing services is limited to 100 days combined per admission. Limit is combined In-Network and Non-Network.</i></p> | \$500 copay per day to a maximum of \$2,000 per admission | 50% coinsurance after deductible is met |
| Hospice | 20% coinsurance | 50% coinsurance after deductible is met |
| Durable Medical Equipment | 20% coinsurance | 50% coinsurance after deductible is met |
| <p>Prosthetic Devices <i>Coverage for wigs after cancer treatment is limited to 1 item per benefit period. Limit is combined In-Network and Non-Network.</i></p> | 20% coinsurance | 50% coinsurance after deductible is met |

Your summary of benefits

| Covered Prescription Drug Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|
| Pharmacy Deductible | Not applicable | Not applicable |
| Pharmacy Out of Pocket | 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 1 - 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. Coverage is also provided for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time.</i> | \$15 copay per prescription, deductible does not apply (retail) and \$38 copay per prescription, deductible does not apply (home delivery) | 50% coinsurance, deductible does not apply (retail) and Not covered (home delivery) |
| 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. Coverage is also provided for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time.</i> | \$45 copay per prescription, deductible does not apply (retail) and \$135 copay per prescription, deductible does not apply (home delivery) | 50% coinsurance, deductible does not apply (retail) and Not covered (home delivery) |
| 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. Coverage is also provided for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time.</i> | 25% coinsurance up to \$200 per prescription, deductible does not apply (retail) and 25% coinsurance up to \$600 per | 50% coinsurance, deductible does not apply (retail) and Not covered (home delivery) |

Your summary of benefits

| Covered Prescription Drug Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|--|---|
| | prescription, deductible does not apply (home delivery) | |
| <p>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></p> | 25% coinsurance up to \$400 per prescription, deductible does not apply (retail and home delivery) | 50% coinsurance, deductible does not apply (retail) and Not covered (home delivery) |

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> <p><i>Only children's vision services count towards your out of pocket limit.</i></p> | | |
| <p>Children's Vision Essential Health Benefits (up to age 19)</p> | | |
| <p>Child Vision Deductible</p> <p>Vision exam <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period.</i></p> | <p>Not Applicable</p> <p>No charge</p> | <p>Not Applicable</p> <p>\$0 copayment up to plan's Maximum Allowed Amount</p> |
| <p>Frames <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.</i></p> | <p>No charge</p> | <p>\$0 copayment up to plan's Maximum Allowed Amount</p> |
| <p>Single Vision Lenses <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.</i></p> | <p>No charge</p> | <p>\$0 copayment up to plan's Maximum Allowed Amount</p> |
| <p>Bifocal Vision Lenses <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.</i></p> | <p>No charge</p> | <p>\$0 copayment up to plan's Maximum Allowed Amount</p> |
| <p>Trifocal Vision Lenses <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.</i></p> | <p>No charge</p> | <p>\$0 copayment up to plan's Maximum Allowed Amount</p> |
| <p>Elective contact lenses <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.</i></p> | <p>No charge</p> | <p>\$0 copayment up to plan's Maximum Allowed Amount</p> |
| <p>Non-Elective Contact Lenses <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.</i></p> | <p>No charge</p> | <p>\$0 copayment up to plan's Maximum Allowed Amount</p> |
| <p>Adult Vision (age 19 and older)</p> <p>Adult Vision Deductible</p> | <p>Not Applicable</p> | <p>Not Applicable</p> |

Your summary of benefits

| Covered Vision Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|--|--|
| Vision exam <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period.</i> | \$20 copay | 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 |

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. 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 12 months.</i> | 0% coinsurance | 30% coinsurance after deductible is met |
| Basic services | 40% coinsurance | 50% coinsurance after deductible is met |
| Major services | 50% coinsurance | 50% coinsurance after deductible is met |
| Medically Necessary Orthodontia services | 50% coinsurance | 50% 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 covered | Not covered |
| Annual maximum | Not covered | Not covered |

Your summary of benefits

Your plan also includes the following Healthy Support & Rewards features.

To see your rewards and additional information log into the Anthem website at anthem.com or call the customer service number on your member ID card.

| | | |
|---|---|----------------------------------|
| My Health Rewards | Subscriber and spouse/domestic partner may earn rewards for participating in this program. If you participate, you will earn points by completing designated activities and milestones. The points will be redeemed for rewards. At each of the three milestones, the member can earn \$50. | Up to \$150 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 \$25 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 \$25 per member per year. |

Your summary of benefits

Notes:

- The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, 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.
- For additional information on this plan, please visit www.sbc.anthem.com to obtain a “Summary of Benefits and Coverage”.
- If readmitted within 72 hours for the same diagnosis of the previous discharge, no additional facility copayment is required.
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- Your copays, coinsurance and deductible count toward your out of pocket amount.

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) 330-1214

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) 330-1214.

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) 330-1214:

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) 330-1214。

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 شفاف، با شماره (855) 330-1214 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) 330-1214.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nempòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (855) 330-1214.

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) 330-1214.

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) 330-1214 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) 330-1214로 문의하십시오.

Language Access Services:

Navajo (Diné): Dii naaltsoos biká'ígíí lahgo bina'idiikidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehj̄ bee nił hodoonih t'áadoo bą́ąh ilínígóó. Ata' halne'ígíí la' bich'į' hadeesdzhíh nínízíngó kojį' hodíílnih (855) 330-1214.

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) 330-1214.

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) 330-1214 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) 330-1214.

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) 330-1214.

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) 330-1214.

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) 330-1214.

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>.