Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your 2024 Contract Code: ABAK

Your Plan: Anthem Clear Choice SG Silver Maine HMO Tiered Options 3500/40%/9100

Your Network: Maine HMO Tiered Options

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. Unless stated otherwise, services received in an office, Ambulatory Surgical Center, or outpatient facility are combined across all outpatient settings. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the Certificate of Insurance or Evidence of Coverage (EOC). If there is a difference between this summary and the Certificate of Insurance or Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge
Mental Health & Substance Use Disorder Services	No charge
Specialist care	$80 copay per visit deductible does not apply

Covered Medical Benefits	Cost if you use a Tier 1 In-Network Provider	Cost if you use a Tier 2 In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	$3,500 person / $7,000 family	$5,300 person / $10,600 family	Not covered
Overall Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period.*	$9,100 person / $18,200 family	$9,100 person / $18,200 family	Not covered

The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per member deductible and per member out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per member deductible or per member out-of-pocket limit.

The deductibles for Tier 1 In-Network and Tier 2 In-Network do not cross apply. The out-of-pocket limits for Tier 1 In-Network and Tier 2 In-Network cross apply, meaning satisfying one helps satisfy the other.

Your copays, coinsurance and deductible count toward your out-of-pocket limit. However, member cost sharing for the following service(s) do not apply toward the out-of-pocket limit: adult vision.

Covered Medical Benefits	Cost if you use a Tier 1 In-Network Provider	Cost if you use a Tier 2 In-Network Provider	Cost if you use an Out-of-Network Provider
Doctor Visits (virtual and office) *Your plan requires the selection of a Primary Care Physician (PCP). A referral from your Primary Care Physician (PCP) is required for Specialist care and most other providers for select covered services. When you select a Value-Based Provider as your PCP, you will not have to pay a Copayment, Deductible, or Coinsurance for PCP visits, x-rays, lab services and Urgent Care when provided by the Value-Based Provider. No member cost share is required for each first primary care and first mental health/substance use disorder doctor visit of the plan year. The copay noted below will apply before the deductible upon your second visit, and thereafter, and will accumulate to your deductible.*			
Primary Care (PCP) and Mental Health and Substance Use Disorder Services *virtual and office*	No charge for the first visit and then $40 copay per visit deductible does not apply	No charge for the first visit and then $70 copay per visit deductible does not apply	Not covered
Specialist Care *virtual and office*	$80 copay per visit deductible does not apply	$110 copay per visit after deductible is met	Not covered
Other Practitioner Visits			
Routine Maternity Care (Prenatal and Postnatal) *In-Network preventive prenatal services are covered at 100%.*	40% coinsurance after deductible is met	50% coinsurance after deductible is met	Not covered
Retail Health Clinic	No charge for the first visit and then $40 copay per visit deductible does not apply	No charge for the first visit and then $70 copay per visit deductible does not apply	Not covered
Chiropractic Services	$40 copay per visit deductible does not apply	$70 copay per visit deductible does not apply	Not covered
Acupuncture *Coverage is limited to 12 visits per benefit period.*	$40 copay per visit deductible does not apply	$70 copay per visit deductible does not apply	Not covered
Other Services in an Office			
Allergy Testing	40% coinsurance after deductible is met	50% coinsurance after deductible is met	Not covered
Prescription Drugs - Dispensed in the office *For the drugs itself dispensed in the office through infusion/injection.*	40% coinsurance after deductible is met	50% coinsurance after deductible is met	Not covered

Covered Medical Benefits	Cost if you use a Tier 1 In-Network Provider	Cost if you use a Tier 2 In-Network Provider	Cost if you use an Out-of-Network Provider
Surgery	40% coinsurance after deductible is met	50% coinsurance after deductible is met	Not covered
Preventive care/screenings/immunizations	No charge	No charge	Not covered
Preventive care for Chronic Conditions *per IRS guidelines*	No charge	No charge	Not covered
Diagnostic Services			
Lab			
Office	$25 copay per visit deductible does not apply	$25 copay per visit deductible does not apply	Not covered
Freestanding Laboratory Facility	$25 copay per visit deductible does not apply	$25 copay per visit deductible does not apply	Not covered
Outpatient Hospital	40% coinsurance after deductible is met	50% coinsurance after deductible is met	Not covered
X-Ray			
Office	40% coinsurance after deductible is met	50% coinsurance after deductible is met	Not covered
Freestanding Radiology Center	$75 copay per visit deductible does not apply	$75 copay per visit deductible does not apply	Not covered
Outpatient Hospital	40% coinsurance after deductible is met	50% coinsurance after deductible is met	Not covered
Advanced Diagnostic Imaging - for example: MRI, PET and CAT scans			
Office	40% coinsurance after deductible is met	50% coinsurance after deductible is met	Not covered
Freestanding Radiology Center	$250 copay per service deductible does not apply	$250 copay per service deductible does not apply	Not covered

Covered Medical Benefits	Cost if you use a Tier 1 In-Network Provider	Cost if you use a Tier 2 In-Network Provider	Cost if you use an Out-of-Network Provider
Outpatient Hospital	40% coinsurance after deductible is met	50% coinsurance after deductible is met	Not covered
Emergency and Urgent Care			
Urgent Care (Walk-In Center) *When you select a Value-Based Provider as your PCP, you will not have to pay a Copayment, Deductible, or Coinsurance for Urgent Care when provided by the Value-Based Provider.*	$40 copay per visit deductible does not apply	Same as In-Network Tier 1	Same as In-Network Tier 1
Emergency Room Facility Services	40% coinsurance after deductible is met	Same as In-Network Tier 1	Same as In-Network Tier 1
Emergency Room Doctor and Other Services	40% coinsurance after deductible is met	Same as In-Network Tier 1	Same as In-Network Tier 1
Ambulance Transportation *Authorized Non-Network non-emergency ambulance services are limited to an Anthem maximum payment of $50,000 per trip.*	40% coinsurance after deductible is met	Same as In-Network Tier 1	Same as In-Network Tier 1
Outpatient Mental Health and Substance Use Disorder Services at a Facility			
Facility Fees	40% coinsurance after deductible is met	50% coinsurance after deductible is met	Not covered
Doctor Services	40% coinsurance after deductible is met	50% coinsurance after deductible is met	Not covered
Outpatient Surgery			
Facility Fees			
Hospital	40% coinsurance after deductible is met	50% coinsurance after deductible is met	Not covered
Ambulatory Surgical Center	$300 copay per visit deductible does not apply	$300 copay per visit deductible does not apply	Not covered
Physician and other services including surgeon fees			

Covered Medical Benefits	Cost if you use a Tier 1 In-Network Provider	Cost if you use a Tier 2 In-Network Provider	Cost if you use an Out-of-Network Provider
Hospital	40% coinsurance after deductible is met	50% coinsurance after deductible is met	Not covered
Ambulatory Surgical Center	No charge	No charge	Not covered
Hospital Stay (all Inpatient stays including Maternity, Mental Health and Substance Use Disorder Services)			
Facility fees (for example, room & board) *Coverage for Inpatient Rehabilitation and Skilled Nursing services is limited to 150 days combined per year.*	40% coinsurance after deductible is met	50% coinsurance after deductible is met	Not covered
Physician and other services including surgeon fees	40% coinsurance after deductible is met	50% coinsurance after deductible is met	Not covered
Home Health Care *Coverage excludes Private Duty nursing services.*	40% coinsurance after deductible is met	50% coinsurance after deductible is met	Not covered
Rehabilitation services (for example, physical/speech/occupational therapy) *Coverage for physical therapy, occupational therapy and speech therapy is limited to 60 visits combined per benefit period.*			
Office	$40 copay per visit deductible does not apply	$70 copay per visit deductible does not apply	Not covered
Outpatient Hospital	40% coinsurance after deductible is met	50% coinsurance after deductible is met	Not covered
Habilitation services (for example, physical/speech/occupational therapy) *Coverage for physical therapy, occupational therapy and speech therapy is limited to 60 visits combined per benefit period.*			
Office	$40 copay per visit deductible does not apply	$70 copay per visit deductible does not apply	Not covered

Covered Medical Benefits	Cost if you use a Tier 1 In-Network Provider	Cost if you use a Tier 2 In-Network Provider	Cost if you use an Out-of-Network Provider
Outpatient Hospital	40% coinsurance after deductible is met	50% coinsurance after deductible is met	Not covered
Pulmonary rehabilitation			
Office	$80 copay per visit deductible does not apply	50% coinsurance after deductible is met	Not covered
Outpatient Hospital	40% coinsurance after deductible is met	50% coinsurance after deductible is met	Not covered
Cardiac rehabilitation *Coverage is limited to 36 visits per episode.*			
Office	$80 copay per visit deductible does not apply	50% coinsurance after deductible is met	Not covered
Outpatient Hospital	40% coinsurance after deductible is met	50% coinsurance after deductible is met	Not covered
Dialysis/Hemodialysis office and outpatient hospital	40% coinsurance after deductible is met	50% coinsurance after deductible is met	Not covered
Chemo/Radiation Therapy office and outpatient hospital	40% coinsurance after deductible is met	50% coinsurance after deductible is met	Not covered
Skilled Nursing Care (in a facility) *Coverage for Inpatient Rehabilitation and Skilled Nursing services is limited to 150 days combined per year.*	40% coinsurance after deductible is met	50% coinsurance after deductible is met	Not covered
Inpatient Hospice	40% coinsurance after deductible is met	50% coinsurance after deductible is met	Not covered
Durable Medical Equipment	40% coinsurance after deductible is met	50% coinsurance after deductible is met	Not covered

Covered Medical Benefits	Cost if you use a Tier 1 In-Network Provider	Cost if you use a Tier 2 In-Network Provider	Cost if you use an Out-of-Network Provider
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period. Coverage for children up to age 19 is limited to 1 hearing aid per hearing-impaired ear every 36 months. Coverage for adults ages 19 and over is limited to $3,000 per hearing aid for each hearing-impaired ear every 36 months. Member cost share for prosthetic limbs from an In-Network provider will not exceed 20% coinsurance after deductible.*	40% coinsurance after deductible is met	50% coinsurance after deductible is met	Not covered

Covered Prescription Drug Benefits	Cost if you use a Tier 1 In-Network Pharmacy	Cost if you use a Tier 2 In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Pharmacy Deductible	Combined with In-Network medical deductible (does not apply to Tier 1a, Tier 1b, Tier 2 drugs)	Combined with In-Network medical deductible (does not apply to Tier 1a, Tier 1b, Tier 2 drugs)	Not covered
Pharmacy Out of Pocket Limit	Combined with In-Network medical out of pocket limit	Combined with In-Network medical out of pocket limit	Not covered
Prescription Drug Coverage **Network:** ***Rx Choice Tiered Network*** **Drug List:** ***Select*** *Drugs not included on the Select drug list will not be covered. Prescription Drugs that we are required to cover by federal law under the "Preventive Care" benefit will be covered with no deductible, copayments or coinsurance when you use an In-Network Pharmacy.*			
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (cost shares noted below)* **Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below). Maintenance medications are available through CarelonRx Pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.* **Specialty Pharmacy** *30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.*			
Tier 1a - Typically Lower Cost Generic *Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at Tier 1 In-Network and Tier 2 In-Network Retail Pharmacies.*	$5 copay per prescription, deductible does not apply (retail) and $13 copay per prescription, deductible does not apply (home delivery)	$35 copay per prescription, deductible does not apply (retail only)	Not covered
Tier 1b - Typically Generic *Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at Tier 1 In-Network and Tier 2 In-Network Retail Pharmacies.*	$25 copay per prescription, deductible does not apply (retail) and $63 copay per prescription, deductible does not apply (home delivery)	$40 copay per prescription, deductible does not apply (retail only)	Not covered

Covered Prescription Drug Benefits	Cost if you use a Tier 1 In-Network Pharmacy	Cost if you use a Tier 2 In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Tier 2 - Typically Preferred Brand *Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at Tier 1 In-Network and Tier 2 In-Network Retail Pharmacies.*	$50 copay per prescription, deductible does not apply (retail) and $150 copay per prescription, deductible does not apply (home delivery)	$65 copay per prescription, deductible does not apply (retail only)	Not covered
Tier 3 - Typically Non-Preferred Brand *Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at Tier 1 In-Network and Tier 2 In-Network Retail Pharmacies.*	$100 copay per prescription after deductible is met (retail) and $300 copay per prescription after deductible is met (home delivery)	$150 copay per prescription after deductible is met (retail only)	Not covered
Tier 4 - Typically Specialty (brand and generic)	$250 copay per prescription after deductible is met (retail and home delivery)	$300 copay per prescription after deductible is met (retail only)	Not covered

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. Not all cost shares for covered services are shown below. Benefits include coverage for member's choice of eyeglass lenses or contact lenses, but not both. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail. *Only children's vision services count towards your out of pocket limit.*		
Children's Vision Essential Health Benefits (up to age 19)		
Child Vision Deductible	Not Applicable	Not Applicable
Vision exam *Coverage for In-Network Providers is limited to 1 exam per benefit period.*	No charge	Not covered
Frames *Coverage for In-Network Providers is limited to 1 unit per benefit period.*	No charge	Not covered
Single Vision Lenses *Coverage for In-Network Providers is limited to 1 unit per benefit period.*	No charge	Not covered
Bifocal Vision Lenses *Coverage for In-Network Providers is limited to 1 unit per benefit period.*	No charge	Not covered
Trifocal Vision Lenses *Coverage for In-Network Providers is limited to 1 unit per benefit period.*	No charge	Not covered
Elective contact lenses *Coverage for In-Network Providers is limited to 1 unit per benefit period.*	No charge	Not covered
Non-Elective Contact Lenses *Coverage for In-Network Providers is limited to 1 unit per benefit period.*	No charge	Not covered
Adult Vision (age 19 and older)		
Adult Vision Deductible	Not Applicable	Not Applicable
Vision exam *Coverage for In-Network Providers is limited to 1 exam per benefit period.*	$20 copay	Not covered
Frames	Not covered	Not covered
Single Vision Lenses	Not covered	Not covered
Bifocal Vision Lenses	Not covered	Not covered
Trifocal Vision Lenses	Not covered	Not covered
Elective contact lenses	Not covered	Not covered
Non-Elective Contact Lenses	Not covered	Not covered

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your dental coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail. *Only children's dental services count towards your out of pocket limit.*		
Children's Dental Essential Health Benefits **Diagnostic and preventive** *Coverage for In-Network Providers is limited to 2 visits per 12 months.*	No charge	Not covered
Basic services	20% coinsurance after deductible is met	Not covered
Major services	50% coinsurance after deductible is met	Not covered
Medically Necessary Orthodontia services	50% coinsurance after deductible is met	Not covered
Cosmetic Orthodontia services	Not covered	Not covered
Deductible	Combined with medical deductible	Not covered
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

Healthy Support & Rewards

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.

Program Name	Program Description	Program Incentive
Smart Rewards (Wellbeing Solutions Engagement Package 200)	Subscriber and spouse/domestic partner may earn rewards when eligible activities are completed and, in some instances, are verified by an Anthem claim.	Up to $200 per member per year

Notes:

- Benefit period refers to calendar year.
- For additional information on this plan, please visit www.sbc.anthem.com to obtain a "Summary of Benefits and Coverage".
- This plan needs further review for Massachusetts Minimum Credible Coverage (MCC) measures based on preliminary MA guidance. The final determination of whether a plan meets or does not meet MCC is up to the determination of the Massachusetts Health Connector. This document should not be used for tax purposes.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services" which is generally coinsurance or coinsurance after your deductible is met.
- The per Member Cost Share for covered prescription insulin drugs used to treat diabetes will not exceed a total of $35 per prescription for a 30-day supply when obtained from a Network Retail Pharmacy. The per Member Cost Share for covered prescription insulin drugs used to treat diabetes will not exceed a total of $105 per prescription for a 90-day supply when obtained from a Network Home Delivery Pharmacy.
- Early Childhood Intervention Services are covered for members through age 2. Early Childhood Intervention Therapies are limited to 40 visits per benefit period.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.
- Human Leukocyte Antigen Testing is covered in full for up to $150. This is a lifetime benefit and any charges incurred in excess of $150 will be the responsibility of the Member.
- Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, 3D mammography, breast ultrasounds and MRIs are covered in full as required by state mandate.

Questions: (855) 330-1098 or visit us at www.anthem.com

ME/SG/Anthem Clear Choice SG Silver Maine HMO Tiered Options 3500/40%/9100/ABAK/01-01-2024

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) 330-1098

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) 330-1098 .

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) 330-1098:

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) 330-1098。

Farsi (فارسي): 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) 330-1098 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) 330-1098.

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) 330-1098.

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) 330-1098.

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) 330-1098 にお電話ください。

Language Access Services:

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(855) 330-1098로 문의하십시오.

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bina'ídiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ąh ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih nínízingo kojį' hodíílnih (855) 330-1098.

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) 330-1098.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (855) 330-1098 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) 330-1098.

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) 330-1098.

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) 330-1098.

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) 330-1098.

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.