



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, <https://eoc.anthem.com/eocdps/ca/aso>. 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/ or call (833) 824-2275 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	\$1,000/single or \$3,000/family for <u>In-Network Providers</u> . \$2,000/single or \$6,000/family for <u>Out-of-Network Providers</u> .	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. Primary Care. <u>Specialist Visit</u> . <u>Preventive Care</u> . Certain <u>Prescription Drugs</u> . For more information see below.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	\$3,500/single or \$7,500/family for <u>In-Network Providers</u> . \$7,000/single or \$15,000/family for <u>Out-of-Network Providers</u> .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> charges (unless <u>balanced billing</u> is prohibited), and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. Bluecard PPO unless you live in a Select Network location – then you would select network applied to your area. See www.anthem.com/ca or call (833) 824-2275 for a list of	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>Out-of-Network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>Out-of-Network Provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

	<u>network providers</u> . Benefits and costs may vary by site of service and how the <u>provider</u> bills.	
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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
		<u>In-Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20/visit, <u>deductible</u> does not apply	30% <u>coinsurance</u>	Virtual visits (Telehealth) benefits available.
	<u>Specialist</u> visit	\$40/visit, <u>deductible</u> does not apply	30% <u>coinsurance</u>	Virtual visits (Telehealth) benefits available.
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge, <u>deductible</u> does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	-----none-----
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	-----none-----
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at http://www.optumrx.com .	Typically Generic (Tier 1)	Retail (30-day): \$15 copay Mail order (90-day): \$30 copay	Retail (30-day): \$15 copay & 25% coinsurance Mail order: Not covered	Generic, preferred, non-preferred brand & specialty drugs: Deductible does not apply. If you choose a brand-name medication when a generic version is available, you will have to pay the generic cost sharing and the difference in cost the 3rd time you fill this medication.
	Typically Preferred Brand & Non-Preferred Generic Drugs (Tier 2)	Retail (30-day): \$30 copay Mail order (90-day): \$60 copay	Retail (30-day): \$30 copay & 25% coinsurance Mail order: Not covered	
	Typically Non-Preferred Brand and Generic drugs (Tier 3)	Retail (30-day): \$60 copay Mail order (90-day): \$120 copay	Retail (30-day): \$60 copay & 25% coinsurance Mail order: Not covered	
	Typically Preferred <u>Specialty</u> (brand and generic) (Tier 4)	Retail & Mail order (90-day): Cost varies depending on drug tier	Retail (90-day): Cost varies depending on drug tier Mail order: Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Pre-certification may be required.
	Physician/surgeon fees	20% <u>coinsurance</u>	30% <u>coinsurance</u>	-----none-----

* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/ca/aso>.

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 need immediate medical attention	<u>Emergency room care</u>	\$250/visit, <u>deductible</u> does not apply	Covered as In-Network	<u>Copayment</u> waived if admitted. No charge for Emergency Room Physician Fee.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	Covered as In-Network	-----none-----
	<u>Urgent care</u>	\$50/visit, <u>deductible</u> does not apply	30% <u>coinsurance</u>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Pre-certification may be required.
	Physician/surgeon fees	20% <u>coinsurance</u>	30% <u>coinsurance</u>	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit \$20/visit, <u>deductible</u> does not apply Other Outpatient No charge	Office Visit 30% <u>coinsurance</u> Other Outpatient 30% <u>coinsurance</u>	Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient -----none-----
	Inpatient services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Pre-certification may be required.
If you are pregnant	Office visits	\$20/visit, <u>deductible</u> does not apply \$40/Specialist visit, deductible does not apply	30% <u>coinsurance</u>	Pre-certification required for inpatient stay that exceeds normal 48 hours normal delivery or 96 hours for cesarean. Cost Sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	-----none-----
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Physical, Occupational & Speech therapy limited to a combined maximum of 40 visits per year.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Pre-certification may be required. 120 days/benefit period for skilled nursing services.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Pre-certification may be required.
	<u>Hospice services</u>	20% <u>coinsurance deductible</u> does not apply	30% <u>coinsurance deductible</u> does not apply	Precertification may be required. 360 days/lifetime. Includes Respite Care.
	Children's eye exam	Not covered	Not covered	-----none-----
	Children's glasses	Not covered	Not covered	

* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/ca/aso>.

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 your child needs dental or eye care	Children's dental check-up	Not covered	Not covered	-----none-----

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"> • Cosmetic Surgery • Eye exams for a child • Weight loss programs | <ul style="list-style-type: none"> • Dental Care (Adult) • Glasses for a child • Routine eye care (Adult) | <ul style="list-style-type: none"> • Dental care (Child) • Long-term care • Routine foot care unless you have been diagnosed with diabetes |
|---|--|---|

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"> • Acupuncture 24 visits/benefit period • Hearing aids • Private-duty nursing | <ul style="list-style-type: none"> • Bariatric surgery (In-Network) • Infertility treatment | <ul style="list-style-type: none"> • Chiropractic care 24 visits/benefit period • Most coverage provided outside the United States. See www.bcbsglobalcore.com |
|--|---|--|

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: Department of Managed Health Care, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725, (888) 466-2219, <https://www.dmhc.ca.gov/>, Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform, or contact Anthem at the number on the back of your ID card. 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 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:

ATTN: Grievance and Appeals, PO Box 54159, Los Angeles, CA 90054-0519

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform

Additionally, a consumer assistance program can help you file your appeal. Contact California Consumer Assistance Program, Operated by the California Department of Managed Health Care, 980 9th Street, Suite 500, Sacramento, CA 95814, (888) 466-2219, <https://www.dmhc.ca.gov/>

* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/ca/aso>.

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? Yes.

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.

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)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <u>plan's</u> overall <u>deductible</u>	\$1,000	■ The <u>plan's</u> overall <u>deductible</u>	\$1,000	■ The <u>plan's</u> overall <u>deductible</u>	\$1,000
■ <u>Specialist copayment</u>	\$40	■ <u>Specialist copayment</u>	\$40	■ <u>Specialist copayment</u>	\$40
■ Hospital (facility) <u>coinsurance</u>	20%	■ Hospital (facility) <u>coinsurance</u>	20%	■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%	■ Other <u>coinsurance</u>	20%	■ Other <u>coinsurance</u>	20%
This EXAMPLE event includes services like: <u>Specialist</u> office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (<i>ultrasounds and blood work</i>) <u>Specialist</u> visit (<i>anesthesia</i>)		This EXAMPLE event includes services like: <u>Primary care physician</u> office visits (<i>including disease education</i>) <u>Diagnostic tests</u> (<i>blood work</i>) <u>Prescription drugs</u> <u>Durable medical equipment</u> (<i>glucose meter</i>)		This EXAMPLE event includes services like: <u>Emergency room care</u> (<i>including medical supplies</i>) <u>Diagnostic test</u> (<i>x-ray</i>) <u>Durable medical equipment</u> (<i>crutches</i>) <u>Rehabilitation services</u> (<i>physical therapy</i>)	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<u>Cost Sharing</u>		<u>Cost Sharing</u>		<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,000	<u>Deductibles</u>	\$900	<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$10	<u>Copayments</u>	\$800	<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$2,300	<u>Coinsurance</u>	\$0	<u>Coinsurance</u>	\$100
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	\$0
The total Peg would pay is	\$3,370	The total Joe would pay is	\$1,750	The total Mia would pay is	\$1,500

The plan would be responsible for the other costs of these EXAMPLE covered services.

Get help in your language

Language Assistance Services

Curious to know what all this says? We would be too. Here's the English version: IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help with translations or interpreter services, in a timely manner, please call the telephone number on the back of your ID card. (TTY/TDD:711).

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

Spanish
IMPORTANTE: ¿Puede leer esta carta? Si no es así, podemos pedirle a alguien que lo ayude a leerla. También puede recibir esta carta escrita en su idioma. Para obtener ayuda oportuna y gratuita con traducciones o servicios de interpretación, llame al número de teléfono que figura en el dorso de su tarjeta de identificación. (TTY/TDD: 711).

Arabic

هام: هل يمكنك قراءة هذه الرسالة؟ إذا لم يكن الأمر كذلك، فيمكننا أن نطلب من شخص ما مساعدتك في قراءتها. قد تتمكن أيضا من الحصول على هذه الرسالة مكتوبة بلغتك. للحصول على مساعدة مجانية في خدمات الترجمة أو الترجمة الفورية، في الوقت المناسب، يرجى الاتصال برقم الهاتف الموجود على ظهر بطاقة ID الهوية الخاصة بك. (TTY/TDD:711).

Armenian

Կարեւոր է. կարողանա՞ւ եք կարդալ այս նամակը: Եթե ոչ, կարող եք օգնել ձեզ կարդալ այն: Դուք կարող եք նաև ստանալ այս նամակը գրավոր՝ ձեր լեզվով: Թարգմանությունների կամ թարգմանչական ծառայությունների անվճար օգնության համար, ժամանակին, խնդրում ենք զանգահարել ձեր ID քարտի հակառակ կողմում նշված հեռախոսահամարով: (TTY/TDD: 711):

Chinese

重要提示：您能讀懂這封信嗎？如果不能，我們可以請人幫您看。您還可以獲得以您的語言寫的此信件。如需及時獲得免費的翻譯或口譯服務協助，請撥打您 ID 卡背面的電話號碼。(TTY/TDD:711)。

Farsi

مهم: می‌توانید این نامه را بخوانید؟ اگر نه، می‌توانیم از کسی بخواهیم که در خواندن آن به شما کمک کند. همچنین ممکن است بتوانید این نامه را به زبان خودتان دریافت کنید. برای دریافت کمک رایگان و به‌موقع در زمینه خدمات ترجمه کتبی یا مترجم شفاهی، لطفاً با شماره تلفن مندرج در پشت کارت ID خود تماس بگیرید. (TTY/TDD:711)

Hindi

महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? यदि नहीं, तो हम किसी को इसे पढ़ने में आपकी सहायता करने के लिए रख सकते हैं। आप इस पत्र को अपनी भाषा में भी लिखवा सकते हैं। अनुवाद या दुभाषिया सेवाओं के संबंध में समय पर निःशुल्क सहायता के लिए कृपया अपने पहचान पत्र के पीछे दिए गए टेलीफोन नंबर पर कॉल करें। (TTY/TDD:711)

Hmong

TSEEM CEEB: Koj puas yeem nyeem tau tsab ntawv no? Yog tias nyeem tsis tau, peb mam kom lwv tus neeg los pab nyeem rau koj.

Koj hais tau kom muab tsab ntawv no sau ua koj yam lus. Rau kev pab txhais ntawv los sis txhais lus pab dawb, kom raws sij hawm, thov hu tus npawb xov tooj nyob sab nraum qab ntawm koj daim npav ID. (TTY/TDD: 711).

Japanese

重要：この手紙は読めますか？そうでない場合は、誰かに読んでもらうのを手伝ってもらうこともできます。このお知らせは、貴方の言語で受け取ることも可能です。翻訳や通訳サービスの無料サポートをご希望の場合は、IDカードの裏面に記載されている電話番号までお電話ください。(TTY/TDD:711)。

Khmer

សំខាន់៖ តើអ្នកអាចអានសំបុត្រនេះបានទេ? បើអត់ទេ យើងអាចមានអ្នកជួយអ្នកឱ្យអានវាបាន។ អ្នកក៏ប្រហែលជាអាចឱ្យសំបុត្រនេះសរសេរជាភាសារបស់អ្នកបានផងដែរ។ ដើម្បីទទួលបានជំនួយដោយឥតគិតថ្លៃជាមួយនឹងការបកប្រែស្រាវជ្រាវអ្នកបកប្រែផ្ទាល់មាត់ទាន់ពេលវេលា សូមទូរសព្ទទៅលេខនៅខាងក្រោយកាត ID របស់អ្នក។ (TTY/TDD:711)។

Korean

중요: 이 서신을 읽으실 수 있습니까? 그렇지 않다면 서신을 읽을 수 있게 도움을 드릴 수 있습니다. 원하시는 언어로 이 서신을 받으실 수도 있습니다. 번역이나 통역 서비스를 무료로 이용하시려면 적시에 ID 카드 뒷면에 있는 전화 번호로 전화해 주십시오. (TTY/TDD: 711).

Punjabi

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਵੀ ਲਿਖਵਾ ਸਕਦੇ ਹੋ। ਅਨੁਵਾਦ ਜਾਂ ਦੁਭਾਸ਼ੀਏ ਸੇਵਾਵਾਂ ਵਿੱਚ ਮੁਫਤ ਮਦਦ ਲਈ, ਸਮੇਂ ਸਿਰ, ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਟੈਲੀਫੋਨ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD:711).

Russian

ВАЖНАЯ ИНФОРМАЦИЯ: Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Чтобы своевременно получить бесплатные услуги письменного или устного перевода, позвоните по номеру телефона, указанному на оборотной стороне вашей идентификационной карты участника. (TTY/TDD: 711).

Tagalog

MAHALAGA: Nababasa mo ba ang sulat na ito? Kung hindi, maaari kaming kumuha ng taong tutulong sa iyo na basahin ito. Maaari mo ring ipasulat ang sulat na ito sa iyong wika. Para sa libreng tulong sa mga pagsasalin o serbisyo ng interpreter, sa isang napapanahong paraan, mangyaring tawagan ang numero ng telepono sa likod ng iyong ID card. (TTY/TDD:711).

Thai

ข้อสำคัญ: คุณสามารถอ่านจดหมายฉบับนี้ได้หรือไม่ ถ้าไม่ เราสามารถหาคนช่วยอ่านให้กับคุณได้ นอกจากนี้คุณยังสามารถขอให้เขียนจดหมายให้ได้ ในภาษาของคุณเอง ขอรับบริการแปลหรือล่ามที่รวดเร็วได้ฟรี กรุณาติดต่อหมายเลขโทรศัพท์ที่ด้านหลังของบัตรประจำตัวของคุณ (TTY/TDD:711).

Vietnamese

QUAN TRỌNG: Quý vị có thể đọc lá thư này không? Nếu không, chúng tôi có thể nhờ ai đó giúp quý vị đọc thư. Quý vị cũng có thể yêu cầu viết lá thư này bằng ngôn ngữ của mình. Để được trợ giúp miễn phí về dịch vụ biên dịch hoặc thông dịch một cách kịp thời, vui lòng gọi số điện thoại ở mặt sau thẻ ID của quý vị. (TTY/TDD: 711).

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We follow state and federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services, in a timely manner, like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279, or if you think you were discriminated against based on race, color, national origin, age, disability, or sex, you can mail a complaint directly to 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. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit

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