

Your summary of benefits



Anthem® Blue Cross

Your 2026 Contract Code: 8ZZX

Your Plan: Anthem Gold Vivity HMO 35/1000 WH

Your Network: Vivity

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 Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

Anthem Blue Cross HMO benefits are covered only when services are provided or coordinated by the primary care physician and authorized by the participating medical group or independent practice association (IPA); except OB/GYN services received within the member's medical group/IPA, and services for mental health and substance use disorders. Benefits are subject to all terms, conditions, limitations, and exclusions of the EOC.

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	\$75 copay per visit deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	\$1,000 person / \$2,000 family	Not covered
Overall 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.</i>	\$6,250 person / \$12,500 family	Not covered
<i>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.</i>		
<i>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.</i>		
Doctor Visits (virtual and office) <i>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.</i>		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Primary Care (PCP) and Mental Health and Substance Use Disorder Services <i>virtual and office</i>	virtual -No charge office -\$35 copay per visit deductible does not apply	Not covered
Specialist Provider <i>virtual and office</i>	\$75 copay per visit deductible does not apply	Not covered
Other Practitioner Visits		
Maternity Doctor services		
Prenatal care	No charge	Not covered
Delivery	No charge	Not covered
Postpartum care	\$35 copay per visit deductible does not apply	Not covered
Retail Health Clinic Visit	\$35 copay per visit deductible does not apply	Not covered
Chiropractic/Manipulation Therapy <i>Coverage is limited to 30 visits per year.</i>	\$15 copay per visit deductible does not apply	Not covered
Acupuncture	\$35 copay per visit deductible does not apply	Not covered
Other Services in an Office		
Allergy Testing	\$75 copay per visit deductible does not apply [‡]	Not covered
Prescription Drugs - Dispensed in the office <i>For the drugs itself dispensed in the office through infusion/injection.</i>	\$250 copay per day deductible does not apply	Not covered
Surgery	\$75 copay per visit deductible does not apply [‡]	Not covered
Preventive care / screenings / immunizations	No charge	Not covered
Preventive care for Chronic Conditions <i>per IRS guidelines</i>	No charge	Not covered
<u>Diagnostic Services</u> Lab		
Office	\$25 copay per visit deductible does not apply	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Freestanding Lab/Reference Lab	\$25 copay per visit deductible does not apply	Not covered
Outpatient Hospital	\$25 copay per visit deductible does not apply	Not covered
<u>Diagnostic Services X-Ray</u>		
Office	\$25 copay per visit deductible does not apply	Not covered
Freestanding Radiology Center	\$25 copay per visit deductible does not apply	Not covered
Outpatient Hospital	\$25 copay per visit deductible does not apply	Not covered
<u>Diagnostic Services Advanced Diagnostic Imaging</u> - for example: MRI, PET and CAT scans		
Office	\$100 copay per day deductible does not apply	Not covered
Freestanding Radiology Center	\$350 copay per day deductible does not apply	Not covered
Outpatient Hospital	\$350 copay per day deductible does not apply	Not covered
<u>Emergency and Urgent Care</u>		
Urgent Care (Office Setting)	\$35 copay per visit deductible does not apply	Covered as In-Network
Emergency Room Facility Services <i>Your copay will be waived if admitted.</i>	\$500 copay per visit after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	No charge	Covered as In-Network
Ambulance Transportation	\$500 copay per trip after deductible is met	Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<u>Outpatient Mental Health and Substance Use Disorder Services at a Facility</u> Facility Fees Doctor Services	\$250 copay per visit deductible does not apply No charge	Not covered Not covered
<u>Outpatient Surgery</u> Facility Fees Hospital Ambulatory Surgical Center Physician and other services including surgeon fees Hospital Ambulatory Surgical Center	\$500 copay per visit after deductible is met \$500 copay per visit after deductible is met No charge No charge	Not covered Not covered Not covered Not covered
<u>Hospital Stay (all Inpatient stays including Maternity, Mental Health and Substance Use Disorder Services)</u> <i>If readmitted within 72 hours for the same condition, no additional facility copay is required. If transferred between facilities, only one copay will apply.</i> Facility fees (for example, room & board) <i>Coverage for Skilled Nursing and Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is limited to 100 days combined per benefit period.</i> Physician and other services including surgeon fees	\$750 copay per admission after deductible is met No charge	Not covered Not covered
<u>Home Health Care</u> <i>Home health visits are limited to 100 visits per benefit period. Benefit limit does not apply to physical, occupational or speech therapy when performed as part of Home Health. Limits are combined for home health care and private duty nursing.</i>	\$75 copay per visit deductible does not apply	Not covered
<u>Therapy Services</u> Rehabilitation services (for example, physical/speech/occupational therapy)		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Office	\$30 copay per visit deductible does not apply	Not covered
Outpatient Hospital	\$30 copay per visit deductible does not apply	Not covered
Habilitation services (for example, physical/speech/occupational therapy)		
Office	\$30 copay per visit deductible does not apply	Not covered
Outpatient Hospital	\$30 copay per visit deductible does not apply	Not covered
Pulmonary rehabilitation office and outpatient hospital	\$75 copay per visit deductible does not apply	Not covered
Cardiac rehabilitation office and outpatient hospital	\$75 copay per visit deductible does not apply	Not covered
Dialysis/Hemodialysis		
Office	\$75 copay per visit deductible does not apply	Not covered
Outpatient Hospital	\$500 copay per visit after deductible is met	Not covered
Chemo/Radiation Therapy		
Office	\$75 copay per visit deductible does not apply	Not covered
Outpatient Hospital	\$150 copay per visit deductible does not apply	Not covered
Skilled Nursing Care (in a facility) <i>Coverage for Skilled Nursing and Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is limited to 100 days combined per benefit period.</i>	\$300 copay per admission after deductible is met	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Inpatient Hospice	\$750 copay per admission after deductible is met	Not covered
Durable Medical Equipment	\$100 copay per visit after deductible is met	Not covered

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an 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 1, Tier 2, Tier 3 drugs)	Combined with In-Network medical deductible (does not apply to Tier 1, Tier 2, Tier 3 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: <i>Rx Choice Tiered Network</i> Drug List: <i>Select</i> <i>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.</i>			
Day Supply Limits: Retail Pharmacy <i>30 day supply (cost shares noted below)</i> Retail 90 Pharmacy <i>90 day supply (cost shares noted below)</i> Home Delivery Pharmacy <i>90 day supply (maximum cost shares noted below). Maintenance medications are available through our home delivery pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.</i> Specialty Pharmacy <i>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.</i>			
Tier 1 - Typically Generic <i>Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies.</i>	\$10 copay per prescription, deductible does not apply (retail) and \$20 copay per prescription, deductible does not apply (home delivery)	\$20 copay per prescription, deductible does not apply (retail only)	Not covered (retail and home delivery)
Tier 2 - Typically Preferred Brand <i>Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies.</i>	\$40 copay per prescription, deductible does not apply (retail) and \$100 copay per prescription, deductible does not apply (home delivery)	\$50 copay per prescription, deductible does not apply (retail only)	Not covered (retail and home delivery)
Tier 3 - Typically Non-Preferred Brand <i>Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies.</i>	\$100 copay per prescription, deductible does not apply (retail) and \$250 copay per prescription, deductible does not	\$110 copay per prescription, deductible does not apply (retail only)	Not covered (retail and home delivery)

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
	apply (home delivery)		
Tier 4 - Typically Specialty (brand and generic)	\$250 copay per prescription after deductible is met (retail and home delivery)	\$250 copay per prescription after deductible is met (retail only)	Not covered (retail and home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<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. Only children's vision services count towards your out-of-pocket limit.</i>		
Children's Vision Essential Health Benefits (up to age 19)		
Child Vision Deductible	Not applicable	Not applicable
Vision Exam <i>Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 exam per benefit period.</i>	No charge	\$0 copayment up to plan's Maximum Allowed Amount
Frames <i>Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.</i>	No charge	\$0 copayment up to plan's Maximum Allowed Amount
Single Vision Lenses <i>Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.</i>	No charge	\$0 copayment up to plan's Maximum Allowed Amount
Bifocal Vision Lenses <i>Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.</i>	No charge	\$0 copayment up to plan's Maximum Allowed Amount
Trifocal Vision Lenses <i>Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.</i>	No charge	\$0 copayment up to plan's Maximum Allowed Amount
Elective Contact Lenses <i>Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.</i>	No charge	\$0 copayment up to plan's Maximum Allowed Amount
Non-Elective Contact Lenses <i>Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.</i>	No charge	\$0 copayment up to plan's Maximum Allowed Amount
Adult Vision (age 19 and older)		
Adult Vision Deductible	Not applicable	Not applicable
Vision Exam <i>Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 exam per benefit period.</i>	\$20 copay	Reimbursed Up to \$30
Frames <i>Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit every 2 benefit periods.</i>	\$130 Allowance	Reimbursed Up to \$45
Single Vision Lenses <i>Coverage for Eye Glass Lenses or Contact Lens In-Network Providers and Out-of-Network Providers is limited to 1 unit every 2 benefit periods.</i>	\$20 copay	Reimbursed Up to \$25
Bifocal Vision Lenses <i>Coverage for Eye Glass Lenses or Contact Lens In-Network Providers and Out-of-Network Providers is limited to 1 unit every 2 benefit periods.</i>	\$20 copay	Reimbursed Up to \$40

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Trifocal Vision Lenses <i>Coverage for Eye Glass Lenses or Contact Lens In-Network Providers and Out-of-Network Providers is limited to 1 unit every 2 benefit periods.</i>	\$20 copay	Reimbursed Up to \$55
Elective Contact Lenses <i>Coverage for Eye Glass Lenses or Contact Lens In-Network Providers and Out-of-Network Providers is limited to 1 unit every 2 benefit periods.</i>	\$80 Allowance	Reimbursed Up to \$60
Non-Elective Contact Lenses <i>Coverage for Eye Glass Lenses or Contact Lens In-Network Providers and Out-of-Network Providers is limited to 1 unit every 2 benefit periods.</i>	No charge	Reimbursed Up to \$210

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<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>		
Children's Dental Essential Health Benefits		
Diagnostic and preventive <i>Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 visit per 6 months.</i>	No charge	No charge
Basic services	20% coinsurance after dental deductible is met	20% coinsurance after dental deductible is met
Major services	50% coinsurance after dental deductible is met	50% coinsurance after dental deductible is met
Medically Necessary Orthodontia services	50% coinsurance after dental deductible is met	50% coinsurance after dental deductible is met
Cosmetic Orthodontia services	Not covered	Not covered
Deductible	\$50	\$50
Adult Dental		
Diagnostic and preventive <i>Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 visit per 6 months.</i>	No charge	No charge
Basic services	20% coinsurance after dental deductible is met	20% coinsurance after dental deductible is met
Major services	50% coinsurance after dental deductible is met	50% coinsurance after dental deductible is met
Deductible	\$50	\$50
Annual maximum	\$1,000	\$1,000

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”.
- If services are rendered by a non-participating provider and your plan includes Out-of-Network benefits, you may be responsible for any difference between the covered plan payment and the actual non-participating provider’s charge.
- For plans with an office visit copay, the copay applies to the actual office visit and additional cost shares may apply for any other service performed in the office (i.e., X-ray, lab, surgery), after any applicable deductible.
- 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.
- ‡ You will pay your PCP or Specialist office visit copay for certain services provided in their office.
- Certain services are subject to the utilization review program or precertification. Before scheduling services, the member must make sure utilization or precertification review is obtained. If utilization or precertification review is not obtained, benefits may be reduced or not paid according to the plan.
- Coverage includes standard fertility preservation services as a basic healthcare service including but are not limited to, injections, cryopreservation and storage for both male and female members when a medically necessary treatment may cause iatrogenic infertility. Member cost share for fertility preservation services is based on provider type and service rendered.
- This health plan includes an Employee Assistance Program (EAP) to support your emotional health and wellness with work life resources, including one-on-one counseling by phone, in person and online. Three counseling visits are available at no charge to a member. EAP member service is accessible 24/7/365.

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Questions: (833) 913-2234 or visit us at www.anthem.com/ca

CA/SG/Anthem Gold Vivity HMO 35/1000 WH/8ZZX/2026

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, please call right away at 1-888-254-2721. (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, podemos pedirle a alguien que le ayude a leerla. También es posible que pueda solicitar que le enviemos esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721 (TTY/TDD: 711).

Arabic

هام: هل تستطيع قراءة هذه الرسالة؟ إذا لم يكن الأمر كذلك، يمكننا أن نطلب من شخص ما مساعدتك في قراءتها. قد تتمكن أيضاً من الحصول على هذه الرسالة مكتوبة بلغتك. للحصول على مساعدة مجانية، يرجى الاتصال على الفور على الرقم 1-888-254-2721. (TTY/TDD: 711)

Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք կարդալ այս նամակը: Եթե ոչ, մենք կարող ենք առաջարկել որևէ մեկի օգնությունը՝ ձեզ համար այն կարդալու համար: Դուք կարող եք նաև այս նամակը ստանալ ձեր լեզվով: Անվճար օգնության համար խնդրում ենք անմիջապես զանգահարել՝ 1-888-254-2721. (TTY/TDD: 711)

Chinese

重要：您能看此信嗎？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。如需免費幫助，請立即致電 1-888-254-2721. (TTY/TDD:711)

Farsi

ما، توانیدمی اگر بخوانید؟ را نامه این توانید می آیا مهم. کند کمک شما به آن خواندن در بخواهیم شخصی از توانیممی. زبان به و کتبی صورت به را نامه این بتوانید است ممکن همچنین با فوراً لطفاً، رایگان کمک دریافت برای. کنید دریافت خودتان تماس (TTY/TDD: 711) 1-888-254-2721. شماره بگیرید.

Hindi

महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में किसी की मदद ले सकते हैं। यह पत्र आप अपनी भाषा में भी लिखवा सकते हैं। निःशुल्क सहायता के लिए, कृपया तुरंत 1-888-254-2721 पर कॉल करें। (टीटीवाई/टीडीडी:711)

Hmong

TSEEM CEEB: Koj puas nyeem tau daim ntawv no? Yog tias tsis tau, peb muaj qee tus neeg pab nyeem nws rau koj. Koj los kuj yuav tau txais ib daim ntawv sau ua kom yam lus. Rau kev pab dawb, thov hu tam sim ntawm 1-888-254-2721. (TTY/TDD: 711)

Japanese

重要：この文書を読むことができますか？読むことができない場合、支援することが可能です。また、日本語で訳されたこの文書を書面で受け取ることができます。無料の支援をご希望の場合、1-888-254-2721 (TTY/TDD:711) にご連絡ください。

Khmner

សំខាន់៖ តើអ្នកអាចអានសំបុត្រនេះបានទេ? បើអត់ទេ យើងអាចមានអ្នកជួយអាន។ អ្នកក៏អាចទទួលបានសំបុត្រនេះសរសេរជាភាសា របស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយ ឥតគិតថ្លៃ សូមទូរស័ព្ទមកភ្លាមៗតាមរយៈលេខ 1-888-254-2721. (TTY/TDD: 711)

Korean

중요: 이 편지를 읽으실 수 있으신가요?
그렇지 않으신 경우, 이를 읽으실 수 있도록
도움을 제공해 드릴 수 있습니다. 귀하의
모국어로 된 편지를 우편으로 받아보실 수도
있습니다. 무상으로 제공되는 도움이
필요하신 경우, 1-888-254-2721번으로 바로
연락해 주십시오. (TTY/TDD: 711)

Punjabi

ਕੀ ਤੁਸੀਂ ਇਹ ਚਿੱਠੀ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ
ਇਸਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ
ਇਸ ਚਿੱਠੀ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਵੀ ਲਿਖ ਸਕਦੇ ਹੋ।
ਮੁਫਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਤੁਰੰਤ ਇਸ 'ਤੇ ਕਾਲ
ਕਰੋ 1-888-254-2721। (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. Для получения
бесплатной помощи звоните по номеру
1-888-254-2721. (TTY/TDD: 711)

Tagalog

MAHALAGA: Mababasa mo ba ang
sulat na ito? Kung hindi, mayroon kaming
makakatulong sa iyo na basahin ito.
Maaari mo ring makuha ang sulat na ito
nang nakasulat sa iyong wika. Para sa
libreng tulong, mangyaring tumawag
kaagad sa 1-888-254-2721.
(TTY/TDD: 711)

Thai

สำคัญ: คุณสามารถอ่านจดหมายนี้ได้หรือไม่
หากคุณอ่านจดหมายนี้ไม่ได้ เราสามารถขอให้
ใครสักคนช่วยคุณอ่านได้ คุณสามารถร้องขอ
จดหมายนี้ที่เขียนในภาษาของคุณได้เช่นกัน
หากต้องการความช่วยเหลือแบบไม่มีค่าใช้จ่าย
โปรดโทรหาเราได้ทันทีที่ 1-888-254-2721.
(TTY/TDD: 711)

Vietnamese

QUAN TRỌNG: Quý vị có đọc được lá thư
này không? Nếu không, chúng tôi có thể
nhờ ai đó giúp quý vị đọc. Quý vị cũng có
thể yêu cầu thư này viết bằng ngôn ngữ
của quý vị. Để được trợ giúp miễn phí,
hãy gọi ngay đến số 1-888-254-2721.
(TTY/TDD: 711)

It's important we treat you fairly

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 <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>