**Summary of Benefits and Coverage:** What this **Plan** Covers & What You Pay for Covered Services **Coverage Period: 07/01/2022 - 06/30/2023**

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|  | **Coverage for:** Individual + Family | **Plan Type: PPO** | |
| **Mayfield City Schools: Anthem Blue Access PPO $700** | |  | |

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| Important Document Description | **The Summary of Benefits and Coverage (SBC) document will help you choose a health** [[**plan**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/)**. The SBC shows you how you and the** [[**plan**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) **would share the cost for covered health care services. NOTE: Information about the cost of this** [[**plan**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) **(called the** [[**premium**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/)**) 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/aso>. For general definitions of common terms, such as [[allowed amount](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/), [[balance billing](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/), [[coinsurance](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/), [[copayment](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/), [[deductible](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/), [[provider](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/), or other underlined terms, see the Glossary. You can view the Glossary at [[www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/)](http://www.healthcare.gov/sbc-glossary/) or call (833) 639-1634 to request a copy. | |

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| **Important Questions** | **Answers** | **Why This Matters:** |
| **What is the overall deductible?** | $700/person or $1,400/family for In-Network Providers. $1,000/person or $2,000/family for Non-Network Providers. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Primary Care Specialist Visit Preventive Care for In-Network Providers. Tier 1 Tier 2 Tier 3 Prescription Drugs for In-Network Providers. | This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at [<https://www.healthcare.gov/coverage/preventive-care-benefits/>](https://www.healthcare.gov/coverage/preventive-care-benefits/). |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | $700/person or $1,400/family for In-Network Providers. Unlimited/person or Unlimited/family for Non-Network Providers. This plan has a separate Out of Pocket Maximum of $5,600/person or $11,200/family for In-Network Providers for Prescription Drugs. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges, health care this plan doesn't cover, and Non-Network Transplants. | Even though you pay these expenses, they don’t count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes, Blue Access. See [www.anthem.com](http://www.anthem.com) or call (833) 639-1634 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

| Important Note on Copayment and Coinsurance | All [[**copayment**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) and [[**coinsurance**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) costs shown in this chart are after your [[**deductible**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) has been met, if a [[**deductible**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) applies. |
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| **Common**  **Medical Event** | **Services You May Need** | **What You Will Pay** | | | **Limitations, Exceptions, & Other Important Information** |
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| **In-Network Provider**  **(You will pay the least)** | **Non-Network Provider**  **(You will pay the most)** | |
| **If you visit a health care provider’s office or clinic** | Primary care visit to treat an injury or illness | $15/visit deductible does not apply | | 20% coinsurance | Virtual visits (Telehealth) benefits available. |
| Specialist visit | $15/visit deductible does not apply | | 20% coinsurance | Virtual visits (Telehealth) benefits available. |
| Preventive care/screening/  immunization | No charge | | 20% coinsurance | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge | | 20% coinsurance | Costs may vary by site of service. |
| Imaging (CT/PET scans, MRIs) | 0% coinsurance | | 20% coinsurance | Costs may vary by site of service. |
| **If you need drugs to treat your illness or condition**  More information about **prescription drug coverage** is available at <http://www.anthem.com/pharmacyinformation/> | Tier 1 - Typically Generic | $5/prescription, deductible does not apply (retail and home delivery) | | Not covered (retail) and Not covered (home delivery) | For more information, refer to “National Direct Drug List” at <http://www.anthem.com/pharmacyinformation/> \*See Prescription Drug section |
| Tier 2 - Typically Preferred Brand & Non-Preferred Generic Drugs | $10/prescription, deductible does not apply (retail and home delivery) | | Not covered (retail) and Not covered (home delivery) |
| Tier 3 - Typically Non-Preferred Brand and Generic drugs | $20/prescription, deductible does not apply (retail and home delivery) | | Not covered (retail) and Not covered (home delivery) |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 0% coinsurance | | 20% coinsurance | --------none-------- |
| Physician/surgeon fees | 0% coinsurance | | 20% coinsurance | --------none-------- |
| **If you need immediate medical attention** | Emergency room care | $125/visit deductible does not apply | | Covered as In-Network | Copay waived if admitted. |
| Emergency medical transportation | 0% coinsurance | | Covered as In-Network | --------none-------- |
| Urgent care | $20/visit deductible does not apply | | $20/visit deductible does not apply | --------none-------- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 0% coinsurance | | 20% coinsurance | 60 days/benefit period for Inpatient physical medicine, rehabilitation including day rehabilitation programs. |
| Physician/surgeon fees | 0% coinsurance | | 20% coinsurance | --------none-------- |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office Visit  $15/visit deductible does not apply  Other Outpatient  0% coinsurance | | Office Visit  20% coinsurance  Other Outpatient  20% coinsurance | Office Visit  Virtual visits (Telehealth) benefits available.  Other Outpatient  --------none-------- |
| Inpatient services | 0% coinsurance | | 20% coinsurance | --------none-------- |
| **If you are pregnant** | Office visits | 0% coinsurance | | 20% coinsurance | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| Childbirth/delivery professional services | 0% coinsurance | | 20% coinsurance |
| Childbirth/delivery facility services | 0% coinsurance | | 20% coinsurance |
| **If you need help recovering or have other special health needs** | Home health care | 0% coinsurance | | 20% coinsurance | 60 visits/benefit period for Home Health and Private Duty Nursing combined. |
| Rehabilitation services | $15/visit deductible does not apply | | 20% coinsurance | Costs may vary by site of service. \*See Therapy Services section. |
| Habilitation services | $15/visit deductible does not apply | | 20% coinsurance |
| Skilled nursing care | 0% coinsurance | | 20% coinsurance | 60 days/benefit period for skilled nursing services. |
| Durable medical equipment | 0% coinsurance | | 20% coinsurance | \*See Durable Medical Equipment Section |
| Hospice services | 0% coinsurance | | 20% coinsurance | 360 days/person/lifetime |
| **If your child needs dental or eye care** | Children’s eye exam | Not covered | | Not covered | \*See Vision Services section |
| Children’s glasses | Not covered | | Not covered |
| Children’s dental check-up | Not covered | | Not covered | --------none-------- |

**Excluded Services & Other Covered Services:**

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| **Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services**.**)** | | |  |  |
| * Acupuncture * Dental care (Adult) * Glasses for a child * Routine foot care | * Bariatric surgery * Dental care (Pediatric) * Hearing aids * Weight loss programs | * Cosmetic surgery * Dental Check-up * Long-term care | | |

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| **Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)** | | |  |  |
| * Chiropractic care 24 visits/benefit period * Private-duty nursing 60 visits/benefit period combined with Home Health | * Infertility treatment $10,000 maximum/ benefit period * Routine eye care (Adult) 1 exam/benefit period | * Most coverage provided outside the United States. See [www.bcbsglobalcore.com](http://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: Ohio Department of Insurance, 50 W. Town Street, Third Floor - Suite 300, Columbus, Ohio 43215, (800) 686-1526, (614) 644-2673, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, [www.cciio.cms.gov](http://www.cciio.cms.gov/), 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](http://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](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) for a denial of a [[claim](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/). 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: Grievances and Appeals, P.O. Box 105568, Atlanta GA 30348-5568  
  
Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, [www.cciio.cms.gov](http://www.cciio.cms.gov/)

**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/No**

If your plan doesn’t meet the MinimumValueStandards, you may be eligible for a premiumtaxcredit to help you pay for a plan through the Marketplace.

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| ***To see examples of how this*** [***plan***](https://www.healthcare.gov/sbc-glossary/#plan) ***might cover costs for a sample medical situation, see the next section.*** |

Important Note on 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.

**About these Coverage Examples:**

**Managing Joe’s Type 2 Diabetes**(a year of routine in-network care of a well-controlled condition)

**Peg is Having a Baby**(9 months of in-network pre-natal care and a hospital delivery)

◼ **The plan’s overall deductible** **$700**

◼ **Specialist *copayment* $15**

◼ **Hospital (facility) *coinsurance* 0%**

◼ **Other** ***coinsurance* 0%**

**This EXAMPLE event includes services**

**like:**

**Specialist** office visits (*prenatal care)*

Childbirth/Delivery Professional Services

Childbirth/Delivery Facility Services

**Diagnostic tests** (*ultrasounds and blood work)*

**Specialist** visit *(anesthesia)*

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| **Total Example Cost** | **$12,700** |

**In this example, Peg would pay:**

|  |  |
| --- | --- |
| ***Cost Sharing*** | |
| Deductibles | $700 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn’t covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$760** |

◼ **The plan’s overall deductible** **$700**

◼ **Specialist *copayment* $15**

◼ **Hospital (facility) *coinsurance* 0%**

◼ **Other** ***coinsurance* 0%**

**This EXAMPLE event includes services**

**like:**

**Primary care physician** office visits (*including disease education)*

**Diagnostic tests** *(blood work)*

**Prescription drugs**

**Durable medical equipment** *(glucose meter)*

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| **Total Example Cost** | **$5,600** |

**In this example, Joe would pay:**

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| --- | --- |
| ***Cost Sharing*** | |
| Deductibles | $0 |
| Copayments | $600 |
| Coinsurance | $0 |
| *What isn’t covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$620** |

**Mia’s Simple Fracture**(in-network emergency room visit and follow up care)

◼ **The plan’s overall deductible** **$700**

◼ **Specialist *copayment* $15**

◼ **Hospital (facility) *coinsurance* 0%**

◼ **Other** ***coinsurance* 0%**

**This EXAMPLE event includes services**

**like:**

**Emergency room care** *(including medical supplies)*

**Diagnostic test** *(x-ray)*

**Durable medical equipment** *(crutches)*

**Rehabilitation services** *(physical therapy)*

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| **Total Example Cost** | **$2,800** |

**In this example, Mia would pay:**

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| --- | --- |
| ***Cost Sharing*** | |
| Deductibles | $700 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn’t covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$700** |

**(TTY/TDD: 711)**

**Albanian (Shqip):** Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (833) 639-1634

**Amharic (አማርኛ):** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (833) 639-1634 ይደውሉ።

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**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՝ (833) 639-1634:

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**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(833) 639-1634。

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| image15 | (833) 639-1634. |

**Dutch (Nederlands):** Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (833) 639-1634.

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**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 (833) 639-1634.

**German (Deutsch):** Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (833) 639-1634.

**Greek (Ελληνικά)** Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (833) 639-1634.

**Gujarati (ગુજરાતી):**  જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (833) 639-1634.

**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 (833) 639-1634.

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**Hmong (White Hmong):** Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (833) 639-1634.

**Igbo (Igbo):** Ọ bụr ụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (833) 639-1634.

**Ilokano (Ilokano):** Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (833) 639-1634.

**Indonesian (Bahasa Indonesia):** Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (833) 639-1634.

**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 (833) 639-1634

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**Kirundi (Kirundi):** Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (833) 639-1634.

**Korean (한국어):** 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(833) 639-1634 로 문의하십시오.

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**Oromo (Oromifaa):** Sanadi kanaa wajiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (833) 639-1634 bilbilla.

**Pennsylvania Dutch (Deitsch):** Wann du Frooge iwwer selle Document hoscht, du hoscht die Recht um Helfe un Information zu griege in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff (833) 639-1634 aa.

**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 (833) 639-1634.

**Portuguese (Português):** Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para (833) 639-1634.

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**Samoan (Samoa):** Afai e iai ni ou fesili e uiga i lenei tusi, e iai lou ‘aia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se totogi. Ina ia talanoa i se tagata faaliliu, vili (833) 639-1634.

**Serbian (Srpski):** Ukoliko imate bilo kakvih pitanja u vezi sa ovim dokumentom, imate pravo da dobijete pomoć i informacije na vašem jeziku bez ikakvih troškova. Za razgovor sa prevodiocem, pozovite (833) 639-1634.

**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 (833) 639-1634.

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