Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Contract Code: 5SD1

Your Plan: Anthem Gold Blue Access 2500/0%/5500

Your Network: Blue Access

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. 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 formal Evidence of Coverage (EOC). If there is a difference between this summary and the Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or Evidence of Coverage (EOC), will prevail.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.*	$2,500 person / $5,000 family	$6,250 person / $12,500 family
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. See notes section for additional information regarding your out of pocket maximum.*	$5,500 person / $11,000 family	$13,750 person / $27,500 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible. Immunizations for children prior to their 6th birthday have No Cost Share for In-Network and Non-Network Charges. This applies to childhood immunizations only, not other preventive care.*	No charge	30% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Office Visit to treat an injury or illness	$30 copay per visit deductible does not apply	30% coinsurance after deductible is met
Specialist Care Office Visit and Online Visit	$50 copay per visit deductible does not apply	30% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prenatal and Post-natal Care *In-Network preventive prenatal services are covered at 100%.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Other Practitioner Visits:		
Medical Chats - *within our mobile app*	No charge	Not Applicable
Retail Health Clinic	$30 copay per visit deductible does not apply	30% coinsurance after deductible is met
Preferred On-line Visit *Includes Mental/Behavioral Health and Substance Abuse Live Health Online is the preferred telehealth solution. (www.livehealthonline.com).*	No charge for the first 3 visits and then $10 copay per visit deductible does not apply	30% coinsurance after deductible is met
Other Participating Provider On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	$30 copay per visit deductible does not apply	30% coinsurance after deductible is met
Chiropractic Services *Coverage is limited to 26 visits per benefit period. Applies to In-Network. Does not include manipulation by a professional provider other than a chiropractor.*	50% coinsurance deductible does not apply	Not covered
Acupuncture	Not covered	Not covered
Other Services in an Office:		
Allergy Testing	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Chemo/Radiation Therapy	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Hemodialysis	0% coinsurance after deductible is met	30% coinsurance after deductible is met

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prescription Drugs *For the drugs itself dispensed in the office through infusion/injection.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Diagnostic Services		
Lab:		
Office *Office Cost Share applies only when Freestanding/Reference Labs are not used.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Lab/Reference Lab	No charge	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
X-Ray:		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Radiology Center	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Radiology Center	0% coinsurance after deductible is met	30% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care *The Urgent Care cost share applies to both office and facility based Urgent Care providers. If your plan includes a copay for Urgent Care and additional services are provided, these services may be subject to deductible and coinsurance.*	$50 copay per visit deductible does not apply	30% coinsurance after deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$400 copay per visit and 0% coinsurance deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	0% coinsurance after deductible is met	Covered as In-Network
Emergency Room Mental/Behavioral Health and Substance Abuse Doctor Services	0% coinsurance deductible does not apply	Covered as In-Network
Ambulance (Air and Ground)	0% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	$30 copay per visit deductible does not apply	30% coinsurance after deductible is met
Facility visit:		
Facility Fees	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor Services	0% coinsurance after deductible is met	30% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Surgery		
Facility Fees:		
Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Surgical Center	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor and Other Services:		
Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Surgical Center	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Hospital Stay (all inpatient stays including Maternity, Mental / Behavioral Health, and Substance Abuse)		
Facility fees (for example, room & board) *Physical Medicine, Rehab & Skilled Nursing Facility limited to 150 days combined per benefit period. Limit is combined In-Network and Non-Network.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor and other services	0% coinsurance after deductible is met	30% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Recovery & Rehabilitation		
Home Care Visits *Coverage is limited to 100 visits per benefit period. Private Duty Nursing included with Home Health Care is limited to 82 visits per benefit period. Limit is combined In-Network and Non-Network. Benefit limit does not apply to Home Infusion Therapy. Limit does not apply to separate Physical or Occupational or Speech Therapy limits, when performed as part of Home Health.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for Occupational Rehabilitation services is limited to 20 visits per benefit period. Coverage for Physical Rehabilitation services is limited to 20 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings. Limit is combined across professional visits and outpatient facilities.*	$30 copay per visit deductible does not apply	30% coinsurance after deductible is met
Outpatient Hospital *Coverage for Occupational Rehabilitation services is limited to 20 visits per benefit period. Coverage for Physical Rehabilitation services is limited to 20 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings. Limit is combined across professional visits and outpatient facilities.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Habilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for Occupational Habilitation services is limited to 20 visits per benefit period. Coverage for Physical Habilitative services is limited to 20 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings. Limit is combined across professional visits and outpatient facilities.*	$30 copay per visit deductible does not apply	30% coinsurance after deductible is met
Outpatient Hospital *Coverage for Occupational Habilitation services is limited to 20 visits per benefit period. Coverage for Physical Habilitative services is limited to 20 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings. Limit is combined across professional visits and outpatient facilities.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Cardiac rehabilitation		
Office Visit *Coverage is limited to 36 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.*	$50 copay per visit deductible does not apply	30% coinsurance after deductible is met
Outpatient Hospital *Coverage is limited to 36 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Skilled Nursing Care (in a facility) *Physical Medicine, Rehab & Skilled Nursing Facility limited to 150 days combined per benefit period. Limit is combined In-Network and Non-Network.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Hospice	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Durable Medical Equipment	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices *Coverage for Wigs after cancer treatment is limited to one (1) per benefit period In-Network Providers and Non-Network Providers combined. Coverage for hearing aids services in each ear is limited to 1 unit every 36 months. Newborn hearing aids no limit. Limit is combined In-Network and Non-Network.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Not applicable	Not applicable	Not applicable
Pharmacy Out of Pocket	Combined with In-Network medical out of pocket maximum	Combined with In-Network medical out of pocket maximum	Combined with Non-Network medical out of pocket maximum
Prescription Drug Coverage *Select Drug List* *This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies.*			
Tier 1 - Typically Generic *Covers up to a 90 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.*	$15 copay per prescription, deductible does not apply (retail) and $38 copay per prescription, deductible does not apply (home delivery)	$25 copay per prescription, deductible does not apply (retail) and $38 copay per prescription, deductible does not apply (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *Covers up to a 90 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.*	$40 copay per prescription, deductible does not apply (retail) and $120 copay per prescription, deductible does not apply (home delivery)	$50 copay per prescription, deductible does not apply (retail) and $120 copay per prescription, deductible does not apply (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *Covers up to a 90 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).*	$80 copay per prescription, deductible does not apply (retail) and	$90 copay per prescription, deductible does not apply (retail) and	50% coinsurance, deductible does not apply (retail) and

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.	$240 copay per prescription, deductible does not apply (home delivery)	$240 copay per prescription, deductible does not apply (home delivery)	Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic) *Covers up to a 30 day supply (retail pharmacy). Covers up to a 30 day supply (home delivery program). No coverage for non-formulary drugs.*	25% coinsurance up to $350 per prescription, deductible does not apply (retail and home delivery)	25% coinsurance up to $450 per prescription, deductible does not apply (retail) and 25% coinsurance up to $350 per prescription, deductible does not apply (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

Your summary of benefits

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
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 and Non-Network Providers is limited to 1 exam per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Frames *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Single Vision Lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Bifocal Vision Lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Trifocal Vision Lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Elective contact lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Non-Elective Contact Lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Adult Vision (age 19 and older)		
Adult Vision Deductible	Not Applicable	Not Applicable

Your summary of benefits

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Vision exam *Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period.*	$20 copay	Reimbursed Up to $30
Frames	Not covered	Not covered
Single Vision Lenses	Not covered	Not covered
Bifocal Vision Lenses	Not covered	Not covered
Trifocal Vision Lenses	Not covered	Not covered
Elective contact lenses	Not covered	Not covered
Non-Elective Contact Lenses	Not covered	Not covered

Your summary of benefits

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
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 and Non-Network Providers is limited to 2 visits per 12 months.*	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Basic services	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Major services	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Medically Necessary Orthodontia services	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Cosmetic Orthodontia services	Not covered	Not covered
Deductible	Combined with medical deductible	Combined with medical deductible
Adult Dental		
Diagnostic and preventive	Not covered	Not covered
Basic services	Not covered	Not covered
Major services	Not covered	Not covered
Deductible	Not covered	Not covered
Annual maximum	Not covered	Not covered

Your summary of benefits

Notes:

- The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.
- For additional information on this plan, please visit www.sbc.anthem.com to obtain a "Summary of Benefits and Coverage".
- If 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.
- Covered dependents are covered through the end of the month in which the child attains age 26.
- Limitations and Cost shares may vary by site of service. You should refer to your formal contract of coverage for details.
- Specialty Provider (SCP) is a professional provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.
- Primary Care Physician (PCP) is a professional provider who is a practitioner and specializes in either family practice, general practice, internal medicine, pediatrics or geriatrics or is any other professional provider as allowed by the plan.
- If your plan includes out-of-network benefits, In-network and out-of-network deductibles, copayments, coinsurance and out-of-pocket maximum amounts are separate and do not accumulate toward each other.
- Pediatric Dental is embedded in all plans.
- Pediatric Vision & Adult vision exam only – is embedded in all plans.
- If your plan includes out of network benefits, all services with calendar year limits are combined both in and out of network.
- Extent of Coverage of Non-Emergency Care Outside the US is Full Access to the BlueCard network.
- Covered accidental dental services are covered up to $3000 per accident for professional services only.
- Elective Abortion - not covered.
- No Charge means you will not have to pay deductible, copayment and/or coinsurance cost shares up to the maximum allowable amount.
- This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.
- Primary Care Physician (PCP) is a professional provider who is a practitioner who specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other professional provider as allowed by the plan.

- If readmitted within 72 hours for the same diagnosis of the previous discharge, no additional facility copayment is required. If transferred between facilities, only one copayment will apply.
- To view your prescription formulary list log on to www.anthem.com/health-insurance/customer-care/forms-library.
- Benefit period refers to calendar year.

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) 330-1101

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 1101-330 (855) .

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) 330-1101:

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) 330-1101。

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 1101-330 (855) 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) 330-1101.

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) 330-1101.

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) 330-1101.

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) 330-1101 にお電話ください。

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(855) 330-1101로 문의하십시오.

Language Access Services:

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bina'idiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí łą' bich'į' hadeesdzih ninízingo kojį' hodíilnih (855) 330-1101.

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) 330-1101.

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) 330-1101 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) 330-1101.

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) 330-1101.

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) 330-1101.

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) 330-1101.

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.