

# Your summary of benefits

Anthem® Blue Cross Life and Health Insurance Company

Your Plan: Student Advantage Health Insurance Plan

Your School: Samuel Merritt University - SHIP

Your Network: Prudent Buyer PPO

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Overall Deductible</b>	\$750 person / \$2,250 family	\$750 person/ \$2,250 family
<b>Overall Out-of-Pocket Limit</b>	\$5,000 person / \$10,000 family	\$10,000 person / \$20,000 family
<p>The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket maximum; in addition, amounts for all covered family members apply to the family deductible and family out-of-pocket maximum. No one member will pay more than the per person deductible or per person out-of-pocket maximum.</p> <p>All medical and prescription drugs deductibles, copayments and coinsurance apply toward the out-of-pocket maximum.</p> <p>In-network and out-of-network deductibles are combined and accumulate toward each other; however, in-network and out-of-network out-of-pocket maximum amounts accumulate separately and do not accumulate toward each other.</p>		
<p><b>Virtual Visits from online provider LiveHealth Online</b> for <i>urgent/acute medical and mental health and substance use disorder care</i> via <a href="http://www.livehealthonline.com">www.livehealthonline.com</a> are covered at \$20 copay per visit deductible does not apply.</p>		
<b>Primary Care (PCP)</b> <i>virtual and office</i>	\$20 copay per visit deductible does not apply	40% coinsurance after deductible is met
<b>Mental Health and Substance Use Disorder Care</b> <i>virtual and office</i>	\$20 copay per visit deductible does not apply	40% coinsurance after deductible is met
<b>Specialist Care</b> <i>virtual and office</i>	\$40 copay per visit deductible does not apply	40% coinsurance after deductible is met
<b><u>Other Practitioner Visits</u></b>		
<b>Routine Maternity Care</b> (Prenatal and Postnatal) <i>In-Network routine prenatal office visits and other preventive prenatal care and screening are covered at 100%.</i>	\$20 copay per pregnancy deductible does not apply	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i></p> <p>Chiropractic Services <i>Coverage is limited to 30 visits per year.</i></p> <p>Acupuncture</p>	<p>\$20 copay per visit deductible does not apply</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><b><u>Other Services in an Office</u></b></p> <p>Allergy Testing</p> <p>Prescription Drugs - <i>Dispensed in the office</i></p> <p>Surgery</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><b>Preventive care / screenings / immunizations</b></p>	<p>No charge</p>	<p>40% coinsurance after deductible is met</p>
<p><b>Preventive care for Chronic Conditions <i>per IRS guidelines</i></b></p>	<p>No charge</p>	<p>40% coinsurance after deductible is met</p>
<p><b><u>Diagnostic Services</u></b></p> <p><b>Lab</b></p> <p>Office</p> <p>Freestanding Lab</p> <p>Outpatient Hospital</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><b>X-Ray</b></p> <p>Office</p> <p>Freestanding Radiology Center</p> <p>Outpatient Hospital</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b>Advanced Diagnostic Imaging</b></p> <p>Office</p> <p>Freestanding Radiology Center</p> <p>Outpatient Hospital</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><b><u>Emergency and Urgent Care</u></b></p> <p><b>Urgent Care</b></p> <p><b>Emergency Room Facility Services</b> <i>Copay waived if admitted.</i></p> <p><b>Emergency Room Doctor and Other Services</b></p> <p><b><u>Emergency Ambulance</u></b></p>	<p>\$20 copay per visit deductible does not apply</p> <p>\$100 copay per visit and then 20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p><b><u>Outpatient Mental Health and Substance Use Disorder Care at a Facility</u></b></p> <p>Facility Fees</p> <p>Doctor Services</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><b><u>Outpatient Surgery</u></b></p> <p><b>Facility Fees</b></p> <p>Hospital</p> <p>Ambulatory Surgical Center</p> <p><b>Doctor and Other Services</b></p> <p>Hospital</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Ambulatory Surgical Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<p><b><u>Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse)</u></b></p> <p><b>Facility Fees</b> <i>Precertification is required. If precertification is not obtained for non-emergency admission at an Out of Network Provider, an additional \$1,500 copay applies.</i></p> <p><b>Human Organ and Tissue Transplants</b> <i>Coverage includes acquisition and transplant procedures, collection and storage.</i></p> <p><b>Doctor and other services</b></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>\$1,500 copay per admission and then 40% coinsurance after deductible is met</p> <p>Not covered</p> <p>40% coinsurance after deductible is met</p>
<p><b><u>Recovery &amp; Rehabilitation</u></b></p> <p><b>Home Health Care</b> <i>Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.</i></p>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<p><b>Rehabilitation services</b></p> <p>Office</p> <p>Outpatient Hospital</p> <p><b>Habilitation services</b></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><b>Chemo/Radiation Therapy</b></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Dialysis/Hemodialysis</b>  Office  Outpatient Hospital	20% coinsurance after deductible is met  20% coinsurance after deductible is met	40% coinsurance after deductible is met  40% coinsurance after deductible is met
<b>Cardiac rehabilitation</b>  Office  Outpatient Hospital	20% coinsurance after deductible is met  20% coinsurance after deductible is met	40% coinsurance after deductible is met  40% coinsurance after deductible is met
<b>Skilled Nursing Care (facility)</b> <i>Coverage is limited to 100 days per benefit period.</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Hospice</b>	20% coinsurance after deductible is met	20% coinsurance after deductible is met
<b>Durable Medical Equipment</b>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Prosthetic Devices</b>	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Pharmacy Deductible</b>	Not applicable	Not applicable
<b>Pharmacy Out of Pocket Limit</b>	Combined with medical out-of-pocket limit	Combined with medical out-of-pocket limit
<b>Prescription Drug Coverage</b> <b>Network: <i>Base Network</i></b> <b>Drug List: <i>Traditional Open</i></b>		
<b>Day Supply Limits:</b> <b>Retail Pharmacy</b> 30 day supply (cost shares noted below) <b>Retail 90 Pharmacy</b> 90 day supply (cost shares noted below) <b>Home Delivery Pharmacy</b> 90 day supply (maximum cost shares noted below) Maintenance medications are available through CarelonRx Mail. <b>Specialty Pharmacy</b> 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.		
<b>Tier 1 - Typically Generic</b> Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies.	\$5 copay per prescription (retail) and \$10 copay per prescription (home delivery)	\$5 copay plus 50% coinsurance up to \$250 per prescription (retail) and Not covered (home delivery)
<b>Tier 2 – Typically Preferred Brand</b> Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies.	\$30 copay per prescription (retail) and \$60 copay per prescription (home delivery)	\$30 copay plus 50% coinsurance up to \$250 per prescription (retail) and Not covered (home delivery)
<b>Tier 3 - Typically Non-Preferred Brand</b> Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies.	\$60 copay per prescription (retail) and \$120 copay per prescription (home delivery)	\$60 copay plus 50% coinsurance up to \$250 per prescription (retail) and Not covered (home delivery)
<b>Tier 4 - Typically Specialty (brand and generic)</b>	20% coinsurance up to \$100 per prescription (retail) and Not covered (home delivery)	Not covered (retail and home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><i>This is a brief outline of your vision coverage. To receive the In-Network benefit, you must use a Blue View Vision Provider. Only children's vision services count towards your out of pocket limit.</i></p>		
<p><b>Children's Vision Essential Health Benefits (up to age 19)</b></p>		
<p><b>Vision exam</b> <i>Limited to 1 exam per benefit period.</i></p>	<p>No charge</p>	<p>Reimbursed Up to \$30</p>
<p><b>Frames</b> <i>Limited to 1 unit per benefit period.</i></p>	<p>No charge</p>	<p>Reimbursed Up to \$45</p>
<p><b>Lenses</b> <i>Limited to 1 unit per benefit period combined with OON Coverage. OON Reimbursement: Single Reimbursed Up to \$25, Bifocal Reimbursed Up to \$40, Trifocal Reimbursed Up to \$55.</i></p>	<p>No charge</p>	<p>Receives Reimbursement</p>
<p><b>Elective Contact Lenses</b> <i>Limited to 1 unit per benefit period.</i></p>	<p>No charge</p>	<p>Reimbursed Up to \$60</p>
<p><b>Non-Elective Contact Lenses</b> <i>Limited to 1 unit per benefit period.</i></p>	<p>No charge</p>	<p>Reimbursed Up to \$210</p>

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<i>This is a brief outline of your dental coverage. Only children's dental services count towards your out of pocket limit.</i>		
<b>Children's Dental Essential Health Benefits</b> <b>Diagnostic and preventive</b> <i>Limited to 1 visit per 6 months.</i>	No charge	No charge
<b>Basic services</b>	20% coinsurance deductible does not apply	20% coinsurance deductible does not apply
<b>Major services</b>	50% coinsurance deductible does not apply	50% coinsurance deductible does not apply
<b>Medically Necessary Orthodontia services</b>	50% coinsurance deductible does not apply	50% coinsurance deductible does not apply
<b>Cosmetic Orthodontia services</b>	Not covered	Not covered
<b>Adult Dental</b>	Not covered	Not covered



**Notes:**

- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- When using a non-network pharmacy, members are responsible for the stated copay & costs in excess of the prescription drug maximum allowed amount. Members will pay upfront and submit a claim form.
- For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to [https://le.anthem.com/pdf?x=CA\\_SH\\_PPO](https://le.anthem.com/pdf?x=CA_SH_PPO).

*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 Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.*

# Get help in your language



## Notice of Language Assistance

Curious to know what all this says? We would be too. Here's the English version:

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-888-254-2721. For more help call the CA Dept. of Insurance at 1-800-927-4357. (TTY/TDD: 711)

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.

### Spanish

Servicios lingüísticos sin costo. Puede tener un intérprete. Puede solicitar que le lean los documentos y algunos puede recibirlos en su idioma. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-888-254-2721. Para obtener ayuda adicional, llame al Departamento de Seguros de California al 1-800-927-4357. (TTY/TDD: 711)

### Arabic

يتم تقديم خدمات اللغة دون مقابل. يمكنك الاستعانة بمترجم. ويمكنك المطالبة بأن تُقرأ لك بعض المستندات وأن يُرسل بعضها بلغتك. للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة التعريف الخاصة بك أو على الرقم 1-888-254-2721. للحصول على مزيد من المساعدة، يُرجى الاتصال بإدارة كاليفورنيا للتأمين على الرقم 1-800-927-4357. (TTY/TDD: 711)

### Armenian

Թարգմանչական անվճար ծառայություններ: Մենք կարող ենք Ձեզ թարգմանչի ծառայություններ առաջարկել Կարող ենք տրամադրել ինչ-որ մեկին, ով փաստաթղթերը կկարդա Ձեզ համար և կուղարկի դրանք Ձեր լեզվով: Օգնություն ստանալու համար զանգահարեք մեզ Ձեզ ID քարտի վրա նշված հեռախոսահամարով կամ 1-888-254-2721 համարով: Լրացուցիչ օգնության համար զանգահարեք Կալիֆոռնիայի ապահովագրության նախարարություն հետևյալ հեռախոսահամարով՝ 1-800-927-4357: (TTY/TDD: 711)

### Chinese

免費語言服務。您能獲得免費的譯員。您能聽到以您的語言讀出的文件內容，也能獲得以您的語言而寫的部分文件。如需協助，請撥打您的 ID 卡上的號碼或者1-888-254-2721聯絡我們。如需更多協助，請撥打1-800-927-4357 聯絡CA Dept. of Insurance。 (TTY/TDD: 711)

### Farsi

خدمات رایگان زبانی. می‌توانید یک مترجم شفاهی بگیرید. می‌توانید بخوانید اسناد را برای شما بخوانند و برخی اسناد نیز به زبان خودتان برایتان ارسال شود. برای دریافت کمک، از طریق شماره فهرست شده در کارت شناسایی‌تان و یا از طریق 1-888-254-2721 با ما تماس بگیرید. برای دریافت کمکی بیشتر با اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تماس بگیرید. (TTY/TDD: 711)

### Hindi

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बिना लागत की भाषा सेवाएँ। आप दुभाषिया प्राप्त कर सकते हैं। आप दस्तावेज़ पढ़वा सकते हैं और कुछ दस्तावेज़ आपको आपकी भाषा में भेजे जा सकते हैं। मदद के लिए, हमें अपने ID कार्ड पर सूचीबद्ध नंबर पर या 1-888-254-2721 पर कॉल करें। अधिक मदद के लिए 1-800-927-4357 पर CA बीमा विभाग कोकॉल करें। (TTY/TDD: 711)

**Hmong**

Tsis Xam Tus Nqi Cov Kev Pab Cuam Ntsig Txog Hom Lus. Koj muaj peev xwm tau txais ib tus neeg txhais lus. Koj muaj peev xwm tau txais cov ntaub ntawv nyeem ua koj hom lus rau koj mloog thiab yuav xa ib co ntaub ntawv sau ua koj hom lus tuaj rau koj. Txog rau kev pab, hu rau peb tus nab npawb xov tooj teev tseg cia nyob rau ntawm koj daim ID los sis 1-888-254-2721. Txog rau kev pab ntxiv, hu xov tooj rau Pab Kas Phais Lub Chaw Ua Hauj Lwm CA tus xov tooj 1-800-927-4357. (TTY/TDD: 711)

**Japanese**

無料言語サービス。通訳サービスを受けられます。希望する言語で文書を読み上げたり、文書を送るサービスも可能です。支援を受けるには、IDカードに記載された番号、または 1-888-254-2721 にお電話ください。支援の詳細は、カリフォルニア州保険局 (1-800-927-4357) にお電話ください。(TTY/TDD: 711)

**Khmer**

សេវាភាសាឥតគិតថ្លៃ។ អ្នកអាចទទួលបានសេវាបកប្រែឬអ្នកបកប្រែ។ អ្នកអាចឱ្យគេអានឯកសារផ្សេងៗជូនអ្នក និងផ្ញើឯកសារជូនអ្នកជាភាសារបស់អ្នក។ ដើម្បីទទួលបានជំនួយ សូមហៅ ទូរស័ព្ទមកយើងតាមលេខដែលបានរាយនៅលើប័ណ្ណ ID របស់អ្នក ឬក៏លេខ 1-888-254-2721។ ដើម្បីទទួលបានជំនួយបន្ថែម សូមហៅទូរស័ព្ទទៅ CA Dept. of Insurance តាមលេខ 1-800-927-4357។(TTY/TDD: 711)

**Korean**

무료 언어 서비스. 번역사를 이용하실 수 있습니다. 귀하의 언어로 녹음되어 작성된 문서를 받아보실 수 있습니다. 도움을 받으시려면 ID 카드에 기재된 번호 또는 1-888-254-2721로 전화하십시오. 다른 도움이 필요하시면 1-800-927-4357로 보험 CA 부서에 문의 주십시오. (TTY/TDD: 711)

**Punjabi**

ਭਿਬਨਾਂ ਿਕਸੇ ਲਾਗਤ ਦੇ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਆ ਪਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਕੋਈ ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਪੜ੍ਹ ਕੇ ਸੁਣਾ ਸਕਦਾ ਹੈ ਅਤੇ ਕੁਝ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਤੁਹਾਨੂੰ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਸਾਨੂੰ ਤੁਹਾਡੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਸੂਚੀਬੱਧ ਨੰਬਰ ਜਾਂ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। ਿਜ਼ਆਦਾ ਮਦਦ ਲਈ, ਸੀਏ ਿਡਪਾਰਟਮੈਂਟ ਔਫ ਇਨਸੂਰੈਂਸ ਨੂੰ 1-800-927-4357 ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

**Russian**

Бесплатные языковые услуги. Вы можете получить услуги устного переводчика. Вам могут прочесть документы или направить некоторые из них на вашем языке. Для получения помощи звоните нам по телефону, указанному на вашей идентификационной карте, или по номеру 1-888-254-2721. Для получения дополнительной помощи звоните в Департамент страхования штата Калифорния по номеру 1-800-927-4357. (TTY/TDD: 711)

**Tagalog**

Mga Libreng Serbisyo para sa Wika. Maaari kayong kumuha ng interpreter. Maaari ninyong ipabasa ang mga dokumento at ipadala ang ilan sa mga ito sa inyo sa wikang ginagamit ninyo. Para sa tulong, tawagan kami sa numerong nakalista sa inyong ID card o sa 1-888-254-2721. Para sa higit pang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. (TTY/TDD: 711)

**Thai**

ไม่มีค่าบริการเกี่ยวกับภาษา ท่านสามารถขอใช้บริการได้ ท่านสามารถขอให้เจ้าหน้าที่อ่านเอกสารได้ท่านฟังและเอกสารบางอย่างจะส่งถึงท่านโดยใช้ภาษาของท่าน หากต้องการความช่วยเหลือ โปรดโทรหาเราตามหมายเลขที่ระบุอยู่บนบัตรประจำตัวของท่านหรือที่หมายเลข 1-888-254-2721 หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรติดตามแผนก CA Dept. of Insurance ที่หมายเลข 1-800-927-4357 (TTY/TDD: 711)

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Vietnamese

Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có thông dịch viên. Quý vị có thể yêu cầu đọc tài liệu cho quý vị nghe và yêu cầu gửi một số tài liệu bằng ngôn ngữ của quý vị cho quý vị. Để được trợ giúp, hãy gọi cho số được ghi trên thẻ ID của quý vị hoặc số 1-888-254-2721. Để được giúp đỡ thêm, hãy gọi cho Sở Bảo Hiểm California (California Department of Insurance) theo số 1-800-927-4357. (TTY/TDD: 711)

### **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>.

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