Your summary of benefits

Anthem

Matthew Thornton Health Plan, Inc./Anthem® Blue Cross and Blue Shield

Your 2025 Contract Code: 8NVZ

Your Plan: Anthem Gold Access Blue New England HMO 3000/0%/5500 RxD

Your Network: Access Blue NE HMO

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, Site of Service Provider, 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 Certificate of Insurance or Evidence of Coverage (EOC). If there is a difference between this summary and the Certificate of Insurance or Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	$20 copay per visit deductible does not apply
Mental Health & Substance Use Disorder Services	$20 copay per visit deductible does not apply
Specialist care	$40 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 *Your plan applies a separate Pharmacy Deductible to prescription drugs obtained at a pharmacy. See the Covered Prescription Drug Benefits section.*	$3,000 person / $6,000 family	Not covered
Overall 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.*	$5,500 person / $11,000 family	Not covered
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. *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.* *Benefits are based on the setting in which covered services are received and how the provider bills.*		
Doctor Visits (virtual and office) *Your plan requires the selection of a Primary Care Physician (PCP). For members up to age 19, visits in an office with In-Network Providers for primary care, and mental health and substance use disorder services are covered at no charge.*		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Preferred PCP *virtual and office*	No charge	Not covered
Primary Care (PCP) *virtual and office*	$20 copay per visit deductible does not apply	Not covered
Mental Health and Substance Use Disorder Services *virtual and office*	$20 copay per visit deductible does not apply	Not covered
Specialist Care *virtual and office*	$40 copay per visit deductible does not apply	Not covered
Other Practitioner Visits		
Maternity Doctor services (prenatal/postnatal care and delivery) *In-Network preventive prenatal services are covered at 100%.*	No charge after deductible is met	Not covered
Retail Health Clinic	$20 copay per visit deductible does not apply	Not covered
Chiropractic Services	$20 copay per visit deductible does not apply	Not covered
Acupuncture *Coverage is limited to 20 visits per benefit period.*	$20 copay per visit deductible does not apply	Not covered
Other Services in an Office		
Allergy Testing	No charge after deductible is met	Not covered
Prescription Drugs - Dispensed in the office *For the drugs itself dispensed in the office through infusion/injection.*	No charge after deductible is met	Not covered
Surgery	No charge after deductible is met	Not covered
Preventive care/screenings/immunizations	No charge	Not covered
Preventive care for Chronic Conditions *per IRS guidelines*	No charge	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Diagnostic Services		
Lab		
Office	No charge	Not covered
Site of Service Provider	No charge	Not covered
Outpatient Hospital	No charge after deductible is met	Not covered
X-Ray		
Office	No charge after deductible is met	Not covered
Site of Service Provider	$150 copay per visit deductible does not apply	Not covered
Outpatient Hospital	No charge after deductible is met	Not covered
Advanced Diagnostic Imaging - for example: MRI, PET and CAT scans		
Office	No charge after deductible is met	Not covered
Site of Service Provider	$250 copay per visit deductible does not apply	Not covered
Outpatient Hospital	No charge after deductible is met	Not covered
Urgent Care		
Walk-in Center/Walk-in Doctor's Office Visit	$20 copay per visit deductible does not apply	Covered as In-Network
Urgent Care Center Visit *In-Network Urgent Care benefit limited to preferred New Hampshire locations. Cost may vary by site of service.*	$100 copay per visit deductible does not apply	Covered as In-Network
Other Urgent Care Services	No charge after deductible is met	Covered as In-Network
Emergency Care		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Emergency Room Facility Services *Your copay will be waived if admitted.*	$350 copay per visit after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	No charge after deductible is met	Covered as In-Network
Emergency Room Doctor Services for Mental Health and Substance Use Disorders	$20 copay per visit after deductible is met	Covered as In-Network
Ambulance Transportation *Authorized Out-of-Network non-emergency ambulance services are limited to an Anthem maximum payment of $50,000 per trip.*	No charge after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	No charge after deductible is met	Not covered
Doctor Services	No charge after deductible is met	Not covered
Outpatient Surgery		
Facility Fees		
Hospital	$500 copay per visit after deductible is met	Not covered
Site of Service Provider	$250 copay per visit deductible does not apply	Not covered
Physician and other services including surgeon fees		
Hospital	No charge after deductible is met	Not covered
Site of Service Provider	No charge	Not covered
Hospital Stay (all Inpatient stays including Maternity, Mental Health and Substance Use Disorder Services)		
Facility fees (for example, room & board) *Coverage for Inpatient Rehabilitation and Skilled Nursing services is limited to 100 days combined per benefit period. Coverage for Inpatient physical medicine and rehabilitation including day rehabilitation programs is limited to 100 days per benefit period.*	No charge 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
Physician and other services including surgeon fees	No charge after deductible is met	Not covered
Home Health Care *Coverage excludes Private Duty nursing services.*	No charge after deductible is met	Not covered
Rehabilitation services (for example, physical/speech/occupational therapy) *Coverage for physical therapy, occupational therapy and speech therapy is limited to 60 visits combined per benefit period.*		
Office	$20 copay per visit deductible does not apply	Not covered
Outpatient Hospital	No charge after deductible is met	Not covered
Habilitation services (for example, physical/speech/occupational therapy) *Coverage for physical therapy, occupational therapy and speech therapy is limited to 60 visits combined per benefit period.*		
Office	$20 copay per visit deductible does not apply	Not covered
Outpatient Hospital	No charge after deductible is met	Not covered
Pulmonary rehabilitation		
Office	$40 copay per visit deductible does not apply	Not covered
Outpatient Hospital	No charge after deductible is met	Not covered
Cardiac rehabilitation		
Office	$40 copay per visit deductible does not apply	Not covered
Outpatient Hospital	No charge after deductible is met	Not covered
Dialysis/Hemodialysis office and outpatient hospital	No charge 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
Chemo/Radiation Therapy office and outpatient hospital	No charge after deductible is met	Not covered
Skilled Nursing Care (in a facility) *Coverage for Inpatient Rehabilitation and Skilled Nursing services is limited to 100 days combined per benefit period.*	No charge after deductible is met	Not covered
Inpatient Hospice	No charge after deductible is met	Not covered
Durable Medical Equipment	No charge after deductible is met	Not covered
Prosthetic Devices	No charge after deductible is met	Not covered

Covered Prescription Drug Benefits	Cost if you use a Tier 1 In-Network Pharmacy	Cost if you use a Tier 2 In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Pharmacy Deductible *combined for Tier 1 In-Network and Tier 2 In-Network Pharmacies*	$250 person / $500 family (does not apply to Tier 1a, Tier 1b drugs)	$250 person / $500 family (does not apply to Tier 1a, Tier 1b 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:** ***Rx Choice Tiered Network*** **Drug List:** ***Select*** *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.*			
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (cost shares noted below)* **Home Delivery Pharmacy** *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.* **Specialty Pharmacy** *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.*			
Tier 1a - Typically Lower Cost Generic *Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at Tier 1 In-Network and Tier 2 In-Network Retail Pharmacies.*	$2 copay per prescription, Pharmacy deductible does not apply (retail) and $4 copay per prescription, Pharmacy deductible does not apply (home delivery)	$12 copay per prescription, Pharmacy deductible does not apply (retail only)	Not covered
Tier 1b - Typically Generic *Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at Tier 1 In-Network and Tier 2 In-Network Retail Pharmacies.*	$20 copay per prescription, Pharmacy deductible does not apply (retail) and $40 copay per prescription, Pharmacy deductible does not apply (home delivery)	$30 copay per prescription, Pharmacy deductible does not apply (retail only)	Not covered

Covered Prescription Drug Benefits	Cost if you use a Tier 1 In-Network Pharmacy	Cost if you use a Tier 2 In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Tier 2 - Typically Preferred Brand *Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at Tier 1 In-Network and Tier 2 In-Network Retail Pharmacies.*	$60 copay per prescription after Pharmacy deductible is met (retail) and $120 copay per prescription after Pharmacy deductible is met (home delivery)	$70 copay per prescription after Pharmacy deductible is met (retail only)	Not covered
Tier 3 - Typically Non-Preferred Brand *Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at Tier 1 In-Network and Tier 2 In-Network Retail Pharmacies.*	30% coinsurance up to $400 per prescription after Pharmacy deductible is met (retail) and 30% coinsurance up to $800 per prescription after Pharmacy deductible is met (home delivery)	40% coinsurance up to $500 per prescription after Pharmacy deductible is met (retail only)	Not covered
Tier 4 - Typically Specialty (brand and generic)	40% coinsurance up to $550 per prescription after Pharmacy deductible is met (retail and home delivery)	50% coinsurance up to $650 per prescription after Pharmacy deductible is met (retail only)	Not covered

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-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** **Vision exam** *Coverage for In-Network Providers is limited to 1 exam per benefit period.*	Not applicable No charge	Not applicable Not covered
Frames *Coverage for In-Network Providers is limited to 1 unit per benefit period.*	No charge	Not covered
Single Vision Lenses *Coverage for In-Network Providers is limited to 1 unit per benefit period.*	No charge	Not covered
Bifocal Vision Lenses *Coverage for In-Network Providers is limited to 1 unit per benefit period.*	No charge	Not covered
Trifocal Vision Lenses *Coverage for In-Network Providers is limited to 1 unit per benefit period.*	No charge	Not covered
Elective contact lenses *Coverage for In-Network Providers is limited to 1 unit per benefit period.*	No charge	Not covered
Non-Elective Contact Lenses *Coverage for In-Network Providers is limited to 1 unit per benefit period.*	No charge	Not covered
Adult Vision (age 19 and older) **Adult Vision Deductible** **Vision exam** *Coverage for In-Network Providers is limited to 1 exam per benefit period.*	Not applicable $20 copay	Not applicable Not covered
Frames *Coverage for In-Network Providers is limited to 1 unit every 2 benefit periods.*	$130 Allowance	Not covered
Single Vision Lenses *Coverage for Eye Glass Lenses or Contact Lens In-Network Providers is limited to 1 unit every 2 benefit periods.*	$20 copay	Not covered
Bifocal Vision Lenses *Coverage for Eye Glass Lenses or Contact Lens In-Network Providers is limited to 1 unit every 2 benefit periods.*	$20 copay	Not covered
Trifocal Vision Lenses	$20 copay	Not covered

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Coverage for Eye Glass Lenses or Contact Lens In-Network Providers is limited to 1 unit every 2 benefit periods.		
Elective contact lenses *Coverage for Eye Glass Lenses or Contact Lens In-Network Providers is limited to 1 unit every 2 benefit periods.*	$80 Allowance	Not covered
Non-Elective Contact Lenses *Coverage for Eye Glass Lenses or Contact Lens In-Network Providers is limited to 1 unit every 2 benefit periods.*	No charge	Not covered

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-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 is limited to 2 visits per 12 months.*	0% coinsurance after deductible is met	Not covered
Basic services	40% coinsurance after deductible is met	Not covered
Major services	50% coinsurance after deductible is met	Not covered
Medically Necessary Orthodontia services	50% coinsurance after deductible is met	Not covered
Cosmetic Orthodontia services	Not covered	Not covered
Deductible	Combined with medical deductible	Not covered
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

Healthy Support & Rewards

To see your rewards and additional information log into the Anthem website at anthem.com or call the customer service number on your member ID card.

- Additional rules and limitations may apply to incentives such as requiring completion of multiple activities in order to earn the rewards.
- You should consult with a tax professional for possible tax implications.

Program Name	Program Description	Program Incentive
Smart Rewards (Wellbeing Solutions Engagement Package 200)	Subscriber and spouse/domestic partner may earn rewards when eligible activities are completed and, in some instances, are verified by an Anthem claim.	Up to $200 per member per year
Gym Reimbursement	Subscriber, spouse, and dependents age 18 and over can get money back for using a gym. Fitness membership dues, up to $400, are covered if you're a member of this plan. Work out 50 times at a qualifying fitness center for each six-month period within your benefit plan year. Benefit plan year is the yearly period of coverage that starts at the effective date of coverage.	

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".
- This plan needs further review for Massachusetts Minimum Credible Coverage (MCC) measures based on preliminary MA guidance. The final determination of whether a plan meets or does not meet MCC is up to the determination of the Massachusetts Health Connector. This document should not be used for tax purposes.
- You can save money on In-Network lab tests, x-rays, ultrasounds, Advanced Diagnostic imaging, and outpatient surgery. Visit https://www.anthem.com/siteofservicenh/ or view your SBC for plan details.
- To view your prescription formulary list log on to http://www.anthem.com/pharmacyinformation/
- 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.
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services" which is generally coinsurance or coinsurance after your deductible is met.
- Early Childhood Intervention Services are covered for members up to age 3. Early Childhood Intervention Therapies are limited to 40 visits per benefit period.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits. Out-of-Network Benefits are not applicable.
- Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, 3D mammography, breast ultrasounds and MRIs are covered in full as required by state mandate.
- 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.
  Exclusions: The services listed below are not covered by this plan. Complete details on exclusions and limitations are stated in the Subscriber Certificate.
    - Any service that is not medically necessary.
    - Any service required by a third party (court ordered services are covered if all of the other terms of the plan are met).
    - Cosmetic surgery.
    - Custodial or convalescent care.
    - Educational testing and therapy.
    - Experimental and/or investigational services except as required by law for clinical trials.
    - Hospitalization for conditions that are not covered.
    - Human organ transplants other than those listed in the Subscriber Certificate as Covered Services.
    - Miscellaneous devices, materials, and supplies, including, but not limited to, dentures and support devices for the feet and corrective shoes.
    - Permanent dental restoration, most oral surgery (general anesthesia, hospital or surgical day care facility charges for dental procedures are covered for certain individuals only to the extent required by law).
    - Personal comfort items.
    - Radial keratotomy or other surgery to correct vision.
    - Routine podiatry footcare unless medically necessary.
    - Services covered by government programs to the extent permitted by law.
    - Services for work-related illness or injury.
    - Services, treatments, procedures or programs for weight or appetite control, weight loss, weight management or control of obesity, except for diabetes education, nutrition counseling, and medically necessary surgical and non-surgical services to treat diseases and ailments caused by or resulting from obesity or morbid obesity.

Questions: (855) 330-1103 or visit us at www.anthem.com

NH/SG/Anthem Gold Access Blue New England HMO 3000/0%/5500 RxD/8NVZ/01-01-2025

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) 330-1103

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 (855) 330-1103 .

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) 330-1103:

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) 330-1103。

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 (855) 330-1103 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) 330-1103.

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) 330-1103.

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) 330-1103.

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) 330-1103 にお電話ください。

Language Access Services:

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(855) 330-1103로 문의하십시오.

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bina'ídiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ąh ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih nínízingo kojį' hodíílnih (855) 330-1103.

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) 330-1103.

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) 330-1103 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) 330-1103.

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) 330-1103.

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) 330-1103.

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) 330-1103.

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.