The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) 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/ca/aso. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call (800) 284-2466 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$200/person or $600/family for All 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. Certain Prescription Drugs. Vision Exam. For more information see below.	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/.
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?	$2,000/person or $4,000/family for In-Network Providers. $2,000/person for Out-of-Network Providers. $5,350/person or $10,200/family for In-Network Pharmacy services.	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?	Prescription Drugs, Pre-Authorization Penalties, Premiums, balance-billing charges (unless balanced billing is prohibited), and health care this plan doesn't cover.	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. See www.anthem.com/find-care/?alphaprefix=JPU or call (855) 333-5730 for a list of network providers. Benefits and costs may vary by site of service and how the provider bills.	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.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-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, deductible does not apply	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)	20% coinsurance	20% coinsurance	$350 maximum/service for Out-of-Network Providers.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	$800 maximum/service for Out-of-Network Providers.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.anthem.com/ca/pharmacy-information/.	Typically Generic (Tier 1)	$5/prescription (retail) and $10/prescription (home delivery)	$5/prescription plus 50% coinsurance up to $250/prescription plus costs in excess of the max allowed amount (retail only)	Maintenance medications are subject to mandatory home delivery services after two retail fills have been dispensed at a retail pharmacy. Maintenance medications may also be filled at Walmart, Costco, Sam's Club, Albertsons, Vons, Pavilions, Safeway and Ralphs for a 90 day supply at 2 X the retail copay. You pay additional copays or coinsurance on all tiers for retail
	Typically Preferred Brand & Non-Preferred Generic Drugs (Tier 2)	$20/prescription (retail) and $40/prescription (home delivery)	$20/prescription plus 50% coinsurance up to $250/prescription costs in excess of the max allowed amount (retail only))	
	Typically Non-Preferred Brand and Generic drugs (Tier 3)	$50/prescription (retail) and $100/prescription (home delivery)	$50/prescription plus 50% coinsurance up to $250/prescription plus costs	

* For more information about limitations and exceptions, see the plan or policy document at https://eoc.anthem.com/eocdps/ca/aso.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
			in excess of the max allowed amount (retail only)	fills that exceed 30 days. Most home delivery is 90-day supply. For more information, refer to "National Drug List" at http://www.anthem.com/ca/pharmacyinformation/ *See Prescription Drug section of the plan or policy document (e.g. evidence of coverage or certificate). **Specialty Drugs:** 30 day max supply
	Typically Preferred Specialty (brand and generic) (Tier 4)	$5 copay per prescription (Generic Specialty); 20% coinsurance up to $100 per prescription (Brand Specialty)	Not covered (retail and home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	$350 maximum/admission for Out-of-Network Providers.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	--------none--------
If you need immediate medical attention	Emergency room care	$50/visit, then 20% coinsurance	Covered as In-Network	Copayment waived if admitted. 20% coinsurance for Emergency Room Physician Fee.
	Emergency medical transportation	20% coinsurance	Covered as In-Network	
	Urgent care	$15/visit, deductible does not apply	20% coinsurance	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	10% coinsurance penalty if Out-of-Network preauthorization is not obtained. $600 maximum/day for Non-Emergency Admissions to Out-of-Network Providers.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	--------none--------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit $15/visit, deductible does not apply Other Outpatient 20% coinsurance	Office Visit 20% coinsurance Other Outpatient 20% coinsurance	Office Visit 988 lifeline/mobile crisis team covered as In-Network. Virtual visits (Telehealth) benefits available. Other Outpatient --------none--------
	Inpatient services	10% coinsurance	20% coinsurance	10% coinsurance penalty if Out-of-Network preauthorization is not obtained. $600 maximum/day for Non-Emergency Admissions to Out-of-Network Providers. 20% coinsurance for Inpatient Physician Fee.
If you are pregnant	Office visits	20% coinsurance	20% coinsurance	Inpatient: 10% coinsurance penalty if Out-of-Network preauthorization is not obtained. $600 maximum/day for Non-Emergency Admissions to Out-of-Network Providers. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). *Coverage includes fertility preservation services, see Fertility Preservation section.
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	20% coinsurance	100 visits/benefit period.
	Rehabilitation services	20% coinsurance	20% coinsurance	*See Therapy Services section.
	Habilitation services	20% coinsurance	20% coinsurance	
	Skilled nursing care	10% coinsurance	20% coinsurance	100 days/benefit period for skilled nursing services.
	Durable medical equipment	20% coinsurance	20% coinsurance	*See Durable Medical Equipment section.
	Hospice services	10% coinsurance	10% coinsurance	--------none--------
	Children's eye exam	No charge, deductible does not apply	$0 copayment up to plan's Maximum Allowed Amount	*See Vision Services section.

* For more information about limitations and exceptions, see the plan or policy document at https://eoc.anthem.com/eocdps/ca/aso.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	--------none--------

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Children's dental check-up
- Glasses for a child
- Non-emergency care when traveling outside the U.S.
- Cosmetic surgery
- Infertility treatment
- Routine foot care unless you have been diagnosed with diabetes
- Dental care (Adult)
- Long-term care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture 12 visits/benefit period
- Hearing aids 1 item(s)/ear every 3 years
- Bariatric surgery (In-Network)
- Private-duty nursing in a Home Setting only
- Chiropractic care 30 visits/benefit period combined with all other therapies
- Routine eye care (Adult) 1 exam/benefit period

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: California Department of Insurance, Consumer Services Division, 300 South Spring Street, South Tower, Los Angeles, CA 90013, (800) 927-HELP (4357) , Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.cciio.cms.gov, or contact Anthem at the number on the back of your ID card. 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 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 for a denial of a claim. 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 4310, Woodland Hills, CA 91365-4310

Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.cciio.cms.gov

* For more information about limitations and exceptions, see the plan or policy document at https://eoc.anthem.com/eocdps/ca/aso.

Additionally, a consumer assistance program can help you file your appeal. Contact California Department of Insurance, 300 South Spring Street, 14th Floor, Los Angeles, CA 90013, 800-927-4357, 800-482-4833 (TTY), https://www.insurance.ca.gov

Does this plan provide Minimum Essential Coverage? Yes/No.

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 Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these 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.

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

The plan's overall deductible	**$200**
Specialist copayment	**$15**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**20%**

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)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$200
Copayments	$10
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,060**

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

The plan's overall deductible	**$200**
Specialist copayment	**$15**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**20%**

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)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$100
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,020**

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

The plan's overall deductible	**$200**
Specialist copayment	**$15**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$200
Copayments	$100
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$700**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Get help in your language

Language Assistance Services

Curious to know what all this says? We would be too. Here's the English version: IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help with translations or interpreter services, in a timely manner, please call the telephone number on the back of your ID card. (TTY/TDD: 711). 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 alternative formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card

Spanish

IMPORTANTE: ¿Puede leer esta carta? Si no puede leerla, podemos hacer que alguien lo ayude a leerla. También es posible que pueda recibir esta carta escrita en su idioma. Para obtener ayuda gratuita con traducciones o servicios de interpretación, de manera oportuna, llame al número de teléfono que figura en el dorso de su tarjeta de identificación. (TTY/TDD: 711). Para obtener más ayuda llame al Departamento de Seguros de California al 1-800-927-4357 (TTY/TDD: 711)

Arabic

هام: هل يمكنك قراءة هذا الخطاب؟ إذا كان لا يمكنك ذلك، يمكننا أن نوفر لك شخصًا ما ليساعدك على قراءته. يمكنك أيضًا الحصول على هذا الخطاب مكتوبًا بلغتك. للحصول على المساعدة المجانية بشأن الترجمات المكتوبة والفورية، وفي الوقت المناسب، يُرجى الاتصال برقم الهاتف المكتوب على ظهر بطاقة ID الخاصة بك. (TTY/TDD: 711) للحصول على المزيد من المساعدة اتصل على إدارة التأمين في CA على الرقم 1-800-927-4357 (TTY/TDD: 711)

Armenian

նամակը: Եթե ոչ, մեր մասնագետներից մեկը կարող է օգնել ձեզ կարդալ այն: Դուք կարող եք նաև այս նամակը ստանալ ձեր լեզվով: Թարգմանությունների կամ թարգմանչական ծառայությունների անվճար և ժամանակին օգնության համար խնդրում ենք զանգահարել ձեր ID քարտի հակառակ կողմում նշված հեռախոսահամարով: (TTY/TDD՝ 711): Ավելի շատ օգնության համար զանգահարեք CA-ի ապահովագրության բաժին՝ 1-800-927-4357 հեռախոսահամարով (TTY/TDD՝ 711):

Chinese

重要提示：您能看此信嗎？如果不能，我們可以請人幫您看。您還可以獲得以您的語言寫的此信件。如需及時獲得免費的翻譯或口譯服務協助，請撥打您 ID 卡背面的電話號碼。(TTY/TDD: 711)。欲取得其他協助，請致電 1-800-927-4357 (TTY/TDD: 711) 與 CA 保險部聯絡。

Farsi

مهم: آیا می‌توانید این نامه را بخوانید؟ اگر نمی‌توانید، می‌توانیم ترتیبی دهیم که کسی در خواندن آن به شما کمک کند. همچنین ممکن است بتوانید این نامه را به‌صورت کتبی به زبان خودتان دریافت کنید. برای کمک رایگان و به‌موقع در خدمات ترجمه کتبی و شفاهی، لطفاً با شماره تلفن مندرج در پشت کارت ID خود تماس بگیرید. (TTY/TDD: 711) برای دریافت کمک بیشتر، با اداره بیمه CA به شماره 1-800-927-4357 (TTY/TDD: 711) تماس بگیرید

Hindi

महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? अगर नहीं, तो हम किसी से इसे पढ़ने में आपकी मदद करवा सकते हैं। आप इस पत्र को अपनी भाषा में भी लिखवा सकते हैं। अनुवाद या दुभाषिया सेवाओं में मुफ़्त मदद के लिए, कृपया समय पर अपने पहचान पत्र के पीछे दिए गए फ़ोन नंबर पर कॉल करें। (TTY/TDD: 711) । अधिक सहायता के लिए कैलिफ़ोर्निया बीमा विभाग को CA 1-800-927-4357 (TTY/TDD: 711) पर कॉल करें।

Hmong

TSEEM CEEB: Koj nyeem puas tau tsab ntawv no? Yog nyeem tsis tau, peb muaj neeg los pab koj nyeem nws. Koj los yeej tuaj yeem tau txais daim ntawv no ua koj yam lus. Kom tau txais kev pab txhais ntaub ntawv los sis cov kev pab cuam txhais lus pab dawb, kom raws sij hawm, thov hu tus npawb xov tooj nyob sab nraum qab ntawm koj daim npawv ID. (TTY/TDD: 711). Rau kev pab ntxiv hu lub CA Lub Tuam Tsev Hauj Lwm ntsig txog Kev Tuav Pov Hwm ntawm 1-800-927-4357 (TTY/TDD: 711)

Japanese

重要：この手紙を読むことができますか？もし読めない場合は、読むのを手伝ってもらうことができます。 また、この手紙をお使いの言語で入手できる場合もあります。翻訳や通訳サービスの無料サポートが必要な場合は、お持ちの ID カード裏面に記載されている電話番号まで、できるだけ早くお電話ください。（TTY/TDD: 711）さらに詳しいサポートが必要な場合は、CA カリフォルニア州保険局までご連連絡ください。電話番号：1-800-927-4357（TTY/TDD: 711）

Khmer

ចំណុចសំខាន់៖ តើអ្នកអាចអានសំបុត្រនេះ ដែរឬទេ? ប្រសិនបើមិនទេនោះ យើងអាចរៀបអ្នកណាម្នាក់ជួយអ្នកអានវាបាន។ អ្នកក៏អាចរៀបគេ សរសេរសំបុត្រនេះជាភាសារបស់អ្នកបានផងដែរ។ សម្រាប់ជំនួយឥតគិតថ្លៃជាមួយនឹងសេវាបកប្រែ ឯកសារ ឬផ្តាល់មាត់រៀបទាន់ពេលវេលា សូមទូរសព្ទ ទៅកាន់លេខនៅផ្នែកខ្នងកាត ID សម្គាល់របស់អ្នក។ (TTY/TDD: 711) ។ សម្រាប់ជំនួយបន្ថែម សូមទូរសព្ទទៅកាន់ក្រសួងធានារ៉ាប់រងនៃរដ្ឋ CA តាមលេខ 1-800-927-4357 (TTY/TDD: 711)

Korean

중요: 이 서신을 읽으실 수 있습니까? 그렇지 않다면 서신을 읽을 수 있게 도움을 드릴 수 있습니다. 원하시는 언어로 이 서신을 받으실 수도 있습니다. 번역이나 통역 서비스를 무료로 적시에 이용하시려면 ID 카드 뒷면에 있는 전화 번호로 전화해 주십시오. (TTY/TDD: 711). 추가 도움이 필요하시면 CA 보험부에 1-800-927-4357 (TTY/TDD: 711) 번으로 전화해 주십시오.

Punjabi

ਮਹੱਤਵਪੂਰਨ ਕੀ ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਵੀ ਲਿਖਵਾ ਸਕਦੇ ਹੋ। ਅਨੁਵਾਦ ਜਾਂ ਦੁਭਾਸ਼ੀਏ ਸੇਵਾਵਾਂ ਵਿੱਚ ਮੁਫ਼ਤ ਮਦਦ ਲਈ, ਸਮੇਂ ਸਿਰ, ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੇ ID ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਟੈਲੀਫੋਨ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711). ਹੋਰ ਮਦਦ ਲਈ CA ਬੀਮਾ ਵਿਭਾਗ ਨੂੰ 1-800-927-4357 (TTY/TDD: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Russian

ВАЖНАЯ ИНФОРМАЦИЯ: Можете ли вы прочитать данное письмо? Если нет, наш сотрудник поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Чтобы своевременно получить бесплатные услуги письменного или устного перевода, позвоните по номеру телефона, указанному на оборотной стороне вашей идентификационной карты участника (TTY/TDD: 711). Для получения дополнительной помощи позвоните в Департамент страхования штата CA по номеру 1-800-927-4357 (TTY/TDD: 711)

Tagalog

MAHALAGA: Puwede mo bang basahin ang sulat na ito? Kung hindi, puwede tayong humanap ng taong tutulong sa iyo na basahin ito. Maaaring matanggap mo rin ang sulat na ito sa iyong wika. Para sa libreng tulong sa pagsasalin-wika o mga serbisyo ng interpreter, na napapanahon, mangyaring tawagan ang numero ng telepono sa likod ng iyong card ng ID. (TTY/TDD: 711). Para sa higit pang tulong tawagan ang Departamentol ng Insurance ng CA sa 1-800-927-4357 (TTY/TDD: 711)

Thai

ข้อสำคัญ: คุณอ่านจดหมายนี้ได้หรือไม่ หากไม่ได้ เรามีคนช่วยอ่านให้คุณหรือสามารถขอให้ส่งจดหมายนี้เป็นภาษาที่คุณต้องการ ขอความช่วยเหลือด้าน การแปลหรือบริการล่ามที่รวดเร็วโดยติดต่อหมายเลขโทรศัพท์ที่ด้านหลังบัตรประจำตัวของคุณ (TTY/TDD: 711). ขอความช่วยเหลือเพิ่มเติมโดยติดต่อ CA ฝ่ายประกันภัยที่หมายเลข 1-800-927-4357 (TTY/TDD: 711).

Vietnamese

QUAN TRỌNG: Quý vị có thể đọc được lá thư này không? Nếu không, chúng tôi có thể bố trí người giúp quý vị đọc. Quý vị cũng có thể yêu cầu nhận lá thư này được viết bằng ngôn ngữ của quý vị. Để được hỗ trợ miễn phí về dịch vụ biên dịch hoặc thông dịch, vui lòng gọi số điện thoại ở mặt sau thẻ ID của quý vị để được hỗ trợ kịp thời. (TTY/TDD: 711). Để được giúp đỡ thêm, hãy gọi Sở Bảo hiểm CA theo số 1-800-927-4357 (TTY/TDD: 711).

It’s important we treat you fairly

We follow state and federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don’t discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. For people whose primary language isn’t English (or have limited proficiency), we offer free language assistance services, in a timely manner, like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279, or if you think you were discriminated against based on race, color, national origin, age, disability, or sex, you can mail a complaint directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf