2021-2022

Xavier University

Student Health Insurance Plan

www.anthem.com/studentadvantage

Anthem Student Advantage

Keeping you at your personal best

A003100HMENABS 06/21

Anthem | STUDENT ADVANTAGE

Important notice

This is a brief description of your student health plan underwritten by Anthem Blue Cross and Blue Shield (Anthem). If you would like more details about your coverage and costs, you can find the complete terms in the policy or plan document online at anthem.com.

Table of contents

Welcome to Anthem Student Advantage

As your new school year begins, it's important to understand your health care benefits and how they work. Your Anthem Student Advantage plan will help guide you through that process with information about who is eligible, what is covered, how much it costs, and the best ways to access care.

What you need to know about Anthem Student Advantage

Who is eligible?

- All full-time domestic undergraduate students taking at least 12 or more credit hours are automatically enrolled in this insurance plan, unless proof of comparable coverage is provided.
- All international students are required to enroll in this insurance plan, unless proof of comparable coverage is provided.

International students with F-1 and J-1 Visas are required to have current health insurance coverage with a U.S. claims address.

The following student groups are also eligible to enroll on a voluntary basis:

- Undergraduate taking 6-11 credit hours
- Graduate students taking six or more credit hours who are enrolled in an organized course of study or degree program given at an academic department of the University
- Students taking less than six credit hours, but who are enrolled in an organized course of study or degree program given by an academic department of the University, or students who are fulfilling a non-coursework requirement of that program (thesis, dissertation etc.).

Dependents are no longer eligible to enroll in this coverage.

To waive online, log onto: xavier.myahpcare.com/waiver

Coverage periods and rates

Coverage will become effective at 12:01 a.m., and will end at 11:59 p.m. on the dates shown below.

Costs and dates of coverage

Medical	Annual 8-1-2021 through 7-31-2022	Spring/Summer 1-1-2022 through 7-31-2022	Summer 5-1-2022 through 7-31-2022
Student	$3,324	$1,930	$838

*The above rates include premiums for the plan and commissions and administrative fees.

Important dates for the coverage period

Open enrollment

You can waive your Anthem Student Advantage if you have comparable coverage.

Fall online waiver period is 6/25/2021 through 8/20/2021

Spring online waiver period is 11/16/2021 through 2/4/2022

If you have **questions about enrollment and waiver options,** visit xavier.myahpcare.com.

Keep in touch with your benefits information

Student Health Center

1714 Cleneay Ave.
Cincinnati, OH 45212
513.745.3022 opt. 3
www.xavier.edu/health-wellness/health/
Monday - Friday
8:30am - 5:00pm

Benefits, eligibility and enrollment

Academic HealthPlans
xavier.myahpcare.com
P.O. Box 1605
Colleyville, TX 76034

Claims and coverage

1-844-412-0752
Anthem Blue Cross Life and Health Insurance Company
PO Box 105187
Atlanta, GA 30348-5187

Easy access to care

Access the care you need, when you need it, and in the way that works best for you.

Sydney Health app

With the Sydney Health[1] app through Anthem Student Advantage, you have instant access to:

- Your member ID card.
- The Find a Doctor tool.
- More information about your plan benefits.
- Health tips that are tailored to you.
- LiveHealth Online and 24/7 NurseLine.
- Student support specialists (through click-to-chat or by phone).

Access the Sydney Health app

Go to the App Store℠ or Google Play™ and search for the Sydney Health app to download it today.

LiveHealth Online

From your mobile device or computer with a webcam, you can use LiveHealth Online to visit with a board-certified doctor, psychiatrist or licensed therapist through live video.[2] To use, go to your Sydney Health app or livehealthonline.com. You can also download the free LiveHealth Online app to sign up.

24/7 NurseLine

Call **1-844-545-1429** to speak to a registered nurse who can help you with health issues like fever, allergy relief, cold and flu symptoms and where to go for care. Nurses can also help you enroll in health management programs if you have specific health conditions, remind you about scheduling important screenings and exams, and more.

Provider finder

Visit www.anthem.com/find-care to find the right doctor or facility close to where you are.

Anthem Student Advantage Xavier University website

Visit student.anthem.com/student/schools/xu to see your health plan information, including providers, benefits, claims, covered drugs and more.

1 Sydney Health is a service mark of CareMarket, Inc.
2 Appointments subject to availability of a therapist. Psychologists or therapists using LiveHealth Online cannot prescribe medications. Online counseling is not appropriate for all kinds of problems. If you are in crisis or have suicidal thoughts, it's important that you seek help immediately. Please call 1-800-784-2433 (National Suicide Prevention Lifeline) or 911 and ask for help. If your issue is an emergency, call 911 or go to your nearest emergency room. LiveHealth Online does not offer emergency services.
LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of Anthem Blue Cross and Blue Shield.

Your summary of benefits

Anthem Blue Cross and Blue Shield

Student health insurance plan:
Xavier University

Your network:
Blue Access 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. Plan benefits are pending approval with the state and subject to change.

Medical

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Student Health Center (SHC) Benefits The Deductible will be waive and benefits will be paid at 100% of billed charges after a $30 copay per visit for Covered Medical Expenses incurred when treatment is rendered at the Student Health Center.		
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.	$500 person	$500 person
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.	$7,150 person	$7,150 person
Preventive care/screening/immunization		
In-network preventive care is not subject to deductible, if your plan has a deductible. Out-of-Network preventive care services for children prior to their 6th birthday have no deductible.	No charge	50% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Office Visit to treat an injury or illness	$35 copay per visit 20% coinsurance	$35 copay per visit 50% coinsurance
Specialist Care Office Visit	$35 copay per visit 20% coinsurance	$35 copay per visit 50% coinsurance
Prenatal and Post-natal Care	Based on setting where service is performed	Based on setting where service is performed
Other Practitioner Visits:		
Retail Health Clinic	$35 copay per visit 20% coinsurance	$35 copay per visit 50% coinsurance
On-line Visit *Live Health Online is the preferred telehealth solutions*	$35 copay per visit 20% coinsurance	$35 copay per visit 50% coinsurance

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Acupuncture	Based on setting where service is performed	Based on setting where service is performed
Other Services in an Office:		
Allergy Testing	Based on setting where service is performed	Based on setting where service is performed
Chemo/Radiation Therapy	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Hemodialysis	20% coinsurance after deductible is met	50% coinsurance after deductible is met
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.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Lab/Reference Lab	No charge	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
X-Ray:		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care (Office Setting)	$35 copay per visit 20% coinsurance	$35 copay per visit 50% coinsurance
Emergency Room Facility Services *Copay waived if admitted*	$250 copay per visit and 20% coinsurance	Covered as In-Network
Emergency Ambulance (Air and Ground)	20% coinsurance after deductible is met	Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Outpatient Mental Health and Substance Use Disorder		
Doctor Office Visit and Online Visit	Based on setting where service is performed	Based on setting where service is performed
Facility visit:		
Facility Fees	Based on setting where service is performed	Based on setting where service is performed
Doctor Services	Based on setting where service is performed	Based on setting where service is performed
Outpatient Surgery		
Facility fees:		
Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and Other Services:		
Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospital Stay (all inpatient stays including maternity, mental/behavioral health, and substance abuse disorder):		
Facility fees (for example, room & board) *Coverage for Inpatient rehabilitation and skilled nursing services combined In-Network Providers and Out-of-Network Providers combined is limited to 60 days per benefit year.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and other services	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Care Visits	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office	$35 copay per visit 20% coinsurance	$35 copay per visit 50% coinsurance
Outpatient Hospital	$35 copay per visit 20% coinsurance	$35 copay per visit 50% coinsurance
Habilitation services (for example, physical/speech/occupational therapy):		
Office	$35 copay per visit 20% coinsurance	$35 copay per visit 50% coinsurance
Outpatient Hospital	$35 copay per visit 20% coinsurance	$35 copay per visit 50% coinsurance

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Cardiac rehabilitation		
Office *Coverage for cardiac rehabilitation is limited to 36 visits per benefit period. Apply to In-Network Providers and Non-Network Providers combined. Visit limits are combined both across outpatient and other professional visits.*	$35 copay per visit 20% coinsurance	$35 copay per visit 50% coinsurance
Outpatient Hospital *Coverage for cardiac rehabilitation is limited to 36 visits per benefit period. Apply to In-Network Providers and Non-Network Providers combined. Visit limits are combined both across outpatient and other professional visits.*	$35 copay per visit 20% coinsurance	$35 copay per visit 50% coinsurance
Skilled Nursing Care (in a facility)	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospice	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Durable Medical Equipment	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs needed after cancer treatment In-Network Providers and Out-of-Network Providers combined is limited to 1 items per benefit period.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Pharmacy

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out of Pocket	Combined with medical out of pocket maximum	Combined with medical out of pocket maximum
Prescription Drug Coverage *Traditional Open 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 Lower Cost Generic *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy).*	$20 copay per Prescription deductible does not apply (retail only). $50 copay per Prescription deductible does not apply (home delivery only).	50% coinsurance after deductible is met
Tier 2 – Typically Preferred Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy).*	$50 copay per Prescription deductible does not apply (retail only). $125 copay per Prescription deductible does not apply (home delivery only).	50% coinsurance after deductible is met
Tier 3 - Typically Non-Preferred Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy).*	$75 copay per Prescription deductible does not apply (retail only). $187.50 copay per Prescription deductible does not apply (home delivery only).	50% coinsurance after deductible is met

Pediatric Vision *Limited to covered persons under the age of 19*.

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.		
Children's Vision Essential Health Benefits (up to age 19) *Limited to covered persons under the age of 19.*		
Child Vision Deductible	None	None
Vision exam *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 exam per benefit period*	$20 copay	Reimbursed Up to $30
Frames *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.*	$0 copay, formulary	Reimbursed Up to $45
Lenses *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.*	$0 copay	$25 reimbursement for Single Vision Lens $40 reimbursement for Bifocal Vision Lens $55 reimbursement for Trifocal Vision Lens
Elective contact lenses *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.*	$0 copay, formulary	Reimbursed Up to $60
Non-Elective Contact Lenses *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.*	$0 copay	Reimbursed Up to $210
Adult Vision (age 19 and older)		
Adult Vision Coverage		
Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.	20% coinsurance	50% coinsurance

Pediatric Dental *Limited to covered persons under the age of 19*.

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 (up to age 19) *Limited to covered persons under the age of 19.*		
Diagnostic and preventive *Coverage for In-Network Providers and Out-of-Network Providers combined is limited to 2 visits per benefit period.*	No charge	No charge
Basic services	40% coinsurance	40% coinsurance
Major services/Prosthodontics	50% coinsurance	50% coinsurance
Endodontic, Periodontics, Oral Surgery	50% coinsurance	50% coinsurance
Medically Necessary Orthodontia services	50% coinsurance	50% coinsurance
Cosmetic Orthodontia services	Not covered	Not covered
Deductible	No Deductible	No Deductible
Adult Dental		
Diagnostic and preventive	Not covered	Not covered
Basic services	Not covered	Not covered
Major services	Not covered	Not covered
Deductible	Not Applicable	Not Applicable
Annual maximum	Not covered	Not covered

Emergency travel assistance

As a participant in the student health plan, you have access to the emergency travel services and benefits when you are traveling over 100 miles from home or outside your home country.

To ensure you have immediate access to assistance if you experience a travel related crisis:

Academic HealthPlans has included Academic Emergency Services (AES) in your Student Health Insurance Plan coverage. AES offers a wide range of services and benefits to provide everything you need to prepare for your international experience, as well as get the help or information you need in a crisis.

Academic Emergency Services Numbers	
To contact Academic Emergency Services from the U.S or Canada, call:	**1-855-873-3555**
To contact Academic Emergency Services from outside the U.S. or Canada, dial the country access code followed by the collect number:	**1-610-263-4660**

Designed with you in mind

Offering you healthy support and easy-to-use benefits to help you stay focused on your education and your future.

Notes

- This Summary of Benefits has been updated to comply with federal and state requirements, including applicable provisions of the 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. This Summary of Benefits, as updated, is subject to the approval of the Ohio Department of Insurance.
- In addition to the benefits described in this summary, coverage may include additional benefits, depending upon the member's home state. The benefits provided in this summary are subject to federal and Ohio laws. There are some states that require more generous benefits be provided to their residents, even if the master policy was not issued in their state. If the member's state has such requirements, we will adjust the benefits to meet the requirements.
- The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to the individual deductible and individual out-of-pocket maximum; in addition, amounts for all family members apply to 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.
- All medical services subject to a coinsurance are also subject to the annual medical deductible.
- Annual out-of-pocket maximums include deductible, copays, coinsurance and prescription drug.
- In network and out-of-network deductible and out-of-pocket maximum are exclusive of each other.
- For plans with an office visit copay, the copay applies to the actual office visit and additional cost shares may apply for any other service performed in the office (for example, X-ray, lab, surgery), after any applicable deductible.
- Preventive care services include physical exam, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunization, health education, intervention services, HIV testing) and additional preventive care for women provided for in the guidance supported by Health Resources and Service Administration.
- For medical emergency care rendered by a non-participating provider or non-contracting hospital, reimbursement is based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- If your plan includes out-of-network benefit and you use a out-of-network provider, you are responsible for any difference between the covered expense and the actual non-participating providers charge.
- Non-emergency, out-of-network air ambulance services are limited to Anthem maximum payment of $50,000 per trip.
- Certain services are subject to the utilization review program. Before scheduling services, the member must make sure utilization review is obtained. If utilization review is not obtained, benefits may be reduced or not paid, according to the plan.
- Certain types of physicians may not be represented in the PPO network in the state where the member receives services. If such physician is not available in the service area, the member's copay is the same as for PPO (with and without pre-notification, if applicable). Member is responsible for applicable copays, deductibles and charges which exceed covered expense.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.
- The family deductible and out-of-pocket maximum are embedded indicating the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; additionally, 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.
- All medical and pharmacy deductibles, copayments and coinsurance apply to the out-of-pocket maximum.
- To view your prescription formulary list log on to www.anthem.com/health-insurance/customer-care/forms-library
- Additional visits may be authorized if medically necessary. Pre-service review must be obtained prior to receiving the additional services.
- If your plan includes out-of-network benefits, all services with calendar/plan year limits are combined both in and out of network.

- Transplants covered only when performed at Centers of Medical Excellence or Blue Distinction Centers.
- Bariatric surgery covered only when performed at Blue Distinction Center for Specialty Care for Bariatric Surgery.
- Skilled nursing facility day limit does not apply to mental health and substance abuse.
- Respite care limited to five consecutive days per admission.
- Freestanding lab and radiology center is defined as services received in a non-hospital based facility.
- Coordination of Benefits: The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverage do not exceed 100% of the covered expense.
- Supply limits for certain drugs may be different; go to Anthem's website or call Customer Service.
- Certain drugs require preauthorization approval to obtain coverage.
- This plan includes custom benefits that may supersede some of the information included in the Limitations and Exclusions list provided here. Please see your EOC for full details on your covered benefits.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.
- Exclusions and Limitations:
  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
  - Services covered by government programs to the extent permitted by law
  - Services for work-related illness or injury
  - Sex changes
  - 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.

Exclusions

Medical

In this section you will find a review of items that are not covered by your Plan. Excluded items will not be covered even if the service, supply, or equipment is Medically Necessary. This section is only meant to be an aid to point out certain items that may be misunderstood as Covered Services. This section is not meant to be a complete list of all the items that are excluded by your Plan. We will have the right to make the final decision about whether services or supplies are Medically Necessary and if they will be covered by your Plan.

1. **Acts of War, Disasters, or Nuclear Accidents**
2. **Administrative Charges**
3. **Alternative / Complementary Medicine**
4. **Charges Over the Maximum Allowed Amount**
5. **Cosmetic Services**
6. **Court Ordered Testing**
7. **Custodial Care**
8. **Experimental or Investigational Services**
9. **Eyeglasses and Contact Lenses**
10. **Health Club Memberships and Fitness Services**
11. **Non-Medically Necessary Services**
12. **Nutritional or Dietary Supplements**
13. **Personal Care and Convenience Items**
14. **Private Duty Nursing**
15. **Stand-By Charges**
16. **Travel Costs**
17. **Vision Services**
18. **Weight Loss Programs**

Pharmacy

In addition to the above Exclusions, certain items are not covered under the Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy benefit:

1. **Clinically-Equivalent Alternatives**
2. **Compound Drugs**
3. **Drugs Prescribed by Providers Lacking Qualifications/ Registrations/Certifications**
4. **Drugs That Do Not Need a Prescription**
5. **Lost or Stolen Drugs**
6. **Non-approved Drugs**
7. **Nutritional or Dietary Supplements**
8. **Off label use**
9. **Over-the-Counter Items**
10. **Weight Loss Drugs**

Access help in your language

If you have any questions about this document, you have the right to help and information in your language at no cost. To talk to an interpreter, call **1-844-412-0752**.

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

يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل بقسم خدمات الأعضاء الموجود على بطاقة هويتك للمساعدة في التحدث إلى مترجم فوري. (TTY/TDD: 711)

Armenian

Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Chinese

您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Farsi

شما این حق را دارید که این اطلاعات و کمکهای مربوط به آن را به زبان خود دریافت کنید. برای کمک دریافت به زبان خود با شماره درج شده روی کارت شناسایی خود با خدمات اعضاء تماس بگیرید. (TTY/TDD: 711)

French

Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

Haitian

Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Italian

Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Japanese

この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Korean

귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Navajo

Bee ná ahóót'i' t'áá ni nizaad k'ehjí níká a'doowoł t'áá jíík'e. Naaltsoos bee atah nílínígíí bee néého' dólzingo nanitinígíí béésh bee hane' í bikáá' áaji' hodíílnih. (TTY/TDD: 711)

Polish

Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Punjabi

ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Russian

Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Spanish

Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Tagalog

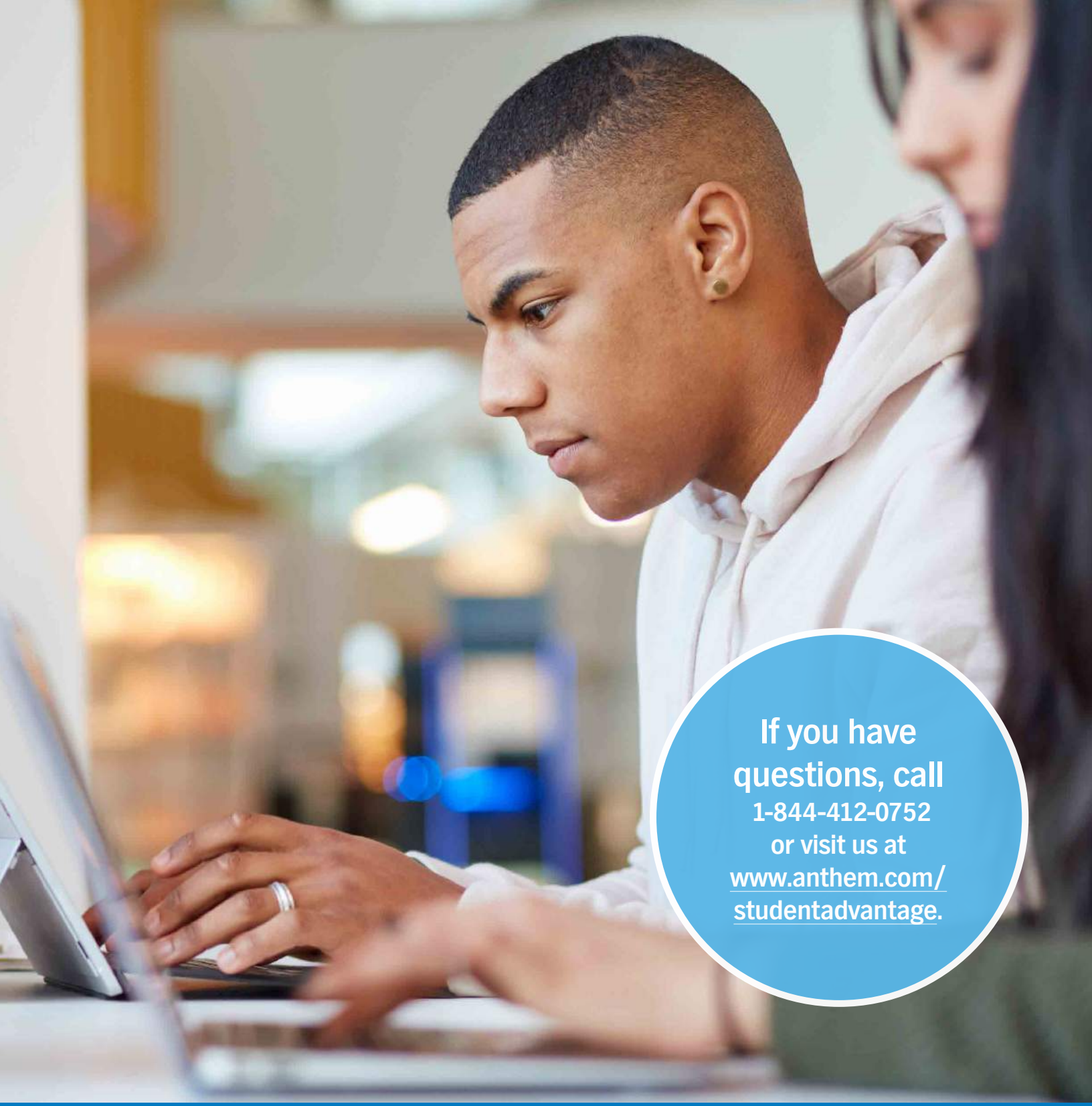
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Vietnamese

Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

It is important we treat you fairly

That is why we follow federal civil rights laws in our health programs and activities. We do not 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 is not English, we offer free language assistance services through interpreters and other written languages. If you are interested in these services, call the Customer Service 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. You can also 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.



If you have questions, call
1-844-412-0752
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