2020-2021

Indiana University International Students and Visiting Scholars

Student Health Insurance Plan

Anthem.com

Anthem Blue Cross and Blue Shield

Keeping you at your personal best

A00355INMENABS 09/20

Anthem

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 Blue Cross and Blue Shield

As your new school year begins, it's important to understand your health care benefits and how they work.

Your Anthem Blue Cross and Blue Shield plan can help keep you at your personal best. This book will guide you through your plan benefits, with information about who is eligible, what is covered, how to access the right type of care when you need it, and more.

What you need to know about Anthem Blue Cross and Blue Shield

Who is eligible?

› Indiana University requires all International Students, Intensive English Program Students (IEP & PIE), and Visiting Scholars to be enrolled in the International Student Insurance Plan. International students required to enroll in the plan are automatically enrolled in and billed for the premium through their bursar account.

Coverage is available for dependents too

Eligible students automatically enrolled and scholars enrolling online may also insure their dependents. This includes a spouse and children under the age of 26. Dependent eligibility is effective and expires concurrently with that of the insured student or scholar. There are two open enrollment periods to enroll a dependent at the start of the fall semester and also the spring semester. In the case of a life event change, if the enrollment form is submitted within 30 days of the qualifying event, coverage will be backdated and begin on the date of the qualifying event. If the deadline has passed, your dependents may not enroll until the next coverage period, unless there has been a significant life change (i.e., marriage, birth, loss of prior coverage).

Here is how it works:

› To enroll the dependent(s) of covered International Students/Scholars, please complete the Enrollment Form available online on the University Health Plans website.

For information about **costs and dates of coverage,** please visit the **Human Resources > Benefits page** on the Indiana University website.

Keep in touch with your benefits information

Student Health Center

BLOOMINGTON CAMPUS
IUB Student Health Center
600 N. Jordan Avenue
Bloomington, IN 47405

Phone Numbers:
Information: 1-812-855-4011
Appointments: 1-812-855-7688
Business Office: 1-812-855-2575
Sexual Assault Crisis Service,
24-hour hotline: 1-812-855-8900
Counseling and Psychological Services: 1-812-855-5711

Please call for current hours.

https://healthcenter.indiana.edu/

INDIANAPOLIS CAMPUS
IUPUI Campus Health
Coleman Hall, Room 100
1140 West Michigan Street
1-317-274-8214
Please call for current hours.

IUPUI CAMPUS CENTER STUDENT HEALTH
Campus Center, Suite 213
420 University Blvd
1-317-274-2274

Please call for current hours.

In the event of an emergency, call 911 or the Campus Police at 1-317-247-7911.

https://health.iupui.edu/

Claims and coverage

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

Benefits, eligibility and enrollment

University Health Plans
universityhealthplans.com

General information

Student Insurance Specialists
1-812-856-4650
studenhc@iu.edu

Easy access to care

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

Sydney Health app

With the Sydney Health[1] app through Anthem Blue Cross and Blue Shield, 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 www.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

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

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:
Indiana University International

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 a Non-Network Provider
Deductible (Single/Family)		
	Single/ Family: $500 per person deductible	Single/ Family: $750 per person deductible
Out-of-Pocket Limit (Single/Family)		
	Single: $2,000 / Family: $4,000	
Indiana University Health Center		
	$15 copay	
Physician Home and Office Services (PCP/SCP)*		
Primary Care Office Visit to treat an injury or illness	$25 copay after deductible	50%
Specialist Care Office Visit	$25 copay after deductible	50%
Other Services in an Office		
Including Office Surgeries and allergy serum:		Not Covered
Allergy injections (PCP and SCP)	$25 copay after deductible	50%
Allergy testing	$25 copay after deductible	50%
MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds, and pharmaceutical products	$20 copay after deductible	50%
Preventive Care Services		
Services included but not limited to: *Routine medical exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Hearing screenings and Vision screenings which are limited to Screening tests (i.e. Snellen eye chart) and Ocular Photo screening*	No copayment/ coinsurance	50%

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency and Urgent Care		
Emergency Room Services facility/other covered services *(copayment waived if admitted)*	$100 copay after deductible	$100 copay after deductible
Urgent Care Center Services	$50 copay after deductible	50%
MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds, and pharmaceutical products	$20 copay after deductible	
Allergy injections	$25 copay after deductible	50%
Allergy testing	$20 copay after deductible	50%
Inpatient and Outpatient Professional Services		
Include, but are not limited to: *Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams*	**Inpatient:** $25 copay after deductible **Outpatient:** $50 copay after deductible	50%
Inpatient Facility Services (Network/Non-Network combined)	$200 copay after deductible	50%
Outpatient Surgery Hospital/Alternative Care Facility		
Surgery and administration of general anesthesia	$100 copay after deductible	50%
Other Outpatient Services (including but not limited to):	$20 copay after deductible	50%
Non Surgical Outpatient Services *For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services.*	$20 copay after deductible	50%
Home Care Services *(Network/Non-Network combined) 100 visits (excludes IV Therapy)*	$20 copay after deductible	50%
Durable Medical Equipment, Orthotics and Prosthetics	20%	20%
Physical Medicine Therapy Day Rehabilitation programs	20%	20%
Hospice Care	$15 copay after deductible	50%
Ambulance Services	0% after deductible	0% after deductible
Outpatient Therapy Services (Combined Network & Non-Network limits apply)		
Physician Home and Office Visits (PCP/SCP)	$15 copay after deductible	50%
Other Outpatient Services @ Hospital/ Alternative Care Facility	$25 copay after deductible (Cardiac Rehabilitation)	50%
Limits apply to: Physical therapy: 60 visits Occupational therapy: 60 Visits Manipulation therapy: 12 visits Speech therapy: 20 visits Cardiac Rehabilitation: unlimited Pulmonary Rehabilitation: unlimited		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Accidental Dental: $3,000 limit per accident (Network and Non-Network combined)	100% after deductible	100% after deductible
Behavioral Health Services		
Mental Illness and Substance Abuse[1]:		
Inpatient Facility Services	$200 copay after deductible	50%
Physician Home and Office Visits (PCP/SCP)	$25/$25 copay after deductible	50%
Other Outpatient Services, Outpatient Facility @ Hospital/ Alternative Care Facility, Outpatient Professional	$25/$25 copay after deductible	50%
Human Organ and Tissue Transplants[2]		
Acquisition and transplant procedures, harvest and storage	20%	50%
Prescription Drug Options: National Formulary **Network Tier structure equals 1/2/3**		
Network Retail Pharmacies: (30-day supply) Includes diabetic test strip	$10/$40/$60	50%[3]
Home Delivery Service: (90-day supply) Includes diabetic test strip	$20/$80/$120	Not covered
Member may be responsible for additional cost when not selecting the available generic drug. Members have additional cost with retail supply greater than 30 days. Specialty Medications must be obtained via our Specialty Pharmacy network in order to receive network level benefits Specialty medications are limited to 30 day supply regardless of whether they are retail or mail order.		

[1] We encourage you to review the Schedule of Benefits for limitations.
[2] Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.
[3] Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.

Vision

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Routine Eye Exam		
A comprehensive eye examination once every plan year	$20 copay	Up to $42 reimbursement
Retinal Imaging		
At member's option can be performed at time of eye exam	Not more than $39	Not covered
Eyeglass Frame		
When purchased as part of a complete pair of eyeglasses*	35% off retail price	Not covered
Eyeglass Lenses (Standard plastic material)		
When purchased as part of a complete pair of eyeglasses*:		
Single Vision	$50	Not covered
Bifocal	$70	Not covered
Trifocal	$105	Not covered
Eyeglass Lens Options and Upgrades		
When purchasing a complete pair of eyeglasses* (frame and lenses), you may choose to upgrade your new eyeglass lenses at a discounted cost. Member costs shown are in addition to the member cost of the standard plastic eyeglass lenses.		
UV Coating	$15	Not covered
Tint (Solid and Gradient)	$15	Not covered

* If frames, lenses or lens options are purchased separately, members will receive a 20% discount instead.
Cannot be combined with any other offer. Discounts are subject to change without notice. Discounts are not 'covered benefits' under your vision plan and will not be listed in your certificate of coverage. Discounts will be offered from in-network providers except where state law prevents discounting of products and services that are not covered benefits under the plan. Discounts on frames will not apply if the manufacturer has imposed a no discount policy on sales at retail and independent provider locations.

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Standard Scratch-Resistant Coating	$15	Not covered
Standard Polycarbonate	$40	Not covered
Standard Anti-Reflective Coating	$45	Not covered
Standard Progressive Lenses (add-on to Bifocal)	$65	Not covered
Other Add-Ons	20% off retail price	Not covered
Conventional Contact Lenses (non-disposable type)		
Discount applies to materials only	15% off retail price	

Dental

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Annual Benefit Maximum – (Plan Year)		
Per insured person	$500	$500
Diagnostic & Preventive Services are not applied to the Annual Benefit Maximum	$500	$500
Annual Maximum Carryover	No	No
Orthodontic Lifetime Benefit Maximum		
Per eligible insured person	Not applicable	Not applicable
Annual Deductible – (Plan Year)		
Per insured person	$25	$25
Family maximum	3x single member deductible	3x single member deductible
Deductible Waived for Diagnostic/Preventive Services	Yes	Yes
Out-of-Network Reimbursement	Maximum Allowed Amount	
Diagnostic and Preventive Services		
Periodic oral exam	100% coinsurance	100% coinsurance
Teeth cleaning (prophylaxis)	100% coinsurance	100% coinsurance
Bitewing X-rays (twice in 12 mos. for all ages)	100% coinsurance	100% coinsurance
Periapical X-rays	100% coinsurance	100% coinsurance

* If frames, lenses or lens options are purchased separately, members will receive a 20% discount instead.
Cannot be combined with any other offer. Discounts are subject to change without notice. Discounts are not 'covered benefits' under your vision plan and will not be listed in your certificate of coverage. Discounts will be offered from in-network providers except where state law prevents discounting of products and services that are not covered benefits under the plan. Discounts on frames will not apply if the manufacturer has imposed a no discount policy on sales at retail and independent provider locations.

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Basic Services		
Amalgam (silver-colored) filling	50% coinsurance	50% coinsurance
Front composite (tooth colored) filling	50% coinsurance	50% coinsurance
Back composite (tooth colored) filling, covered as composite	50% coinsurance	50% coinsurance
Simple extractions	50% coinsurance	50% coinsurance
Endodontics		
Root canal	50% coinsurance	50% coinsurance
Periodontics		
Scaling and root planing	50% coinsurance	50% coinsurance
Oral Surgery		
Surgical extractions	50% coinsurance	50% coinsurance
Major Services		
Crowns	50% coinsurance	50% coinsurance
Prosthodontics		
Dentures	50% coinsurance	50% coinsurance
Bridges	50% coinsurance	50% coinsurance
Dental implants (not covered)	Not covered	Not covered
Prosthetic Repairs/Adjustments	50% coinsurance	50% coinsurance
Orthodontic Services		
Not covered	Not covered	Not covered

This is not a contract; it is a partial listing of benefits and services. All covered services are subject to the conditions, limitations, exclusions, terms and provisions of your certificate of coverage. **In the event of a discrepancy between the information in this summary and the certificate of coverage, the certificate will prevail.**

Emergency dental treatment for the international traveler

As an Anthem dental member, you and your eligible, covered dependents automatically have access to the International Emergency Dental Program.* With this program, you may receive emergency dental care from our listing of credentialed dentists while traveling or working nearly anywhere in the world.

* The International Emergency Dental Program is managed by an independent company offering dental-management services to Anthem. To learn more about the program, please visit the International Emergency Dental Web site at www.decare.com/internationalDentalProgram.do.

Promoting healthy mouths for members who are pregnant or living with diabetes

If you are pregnant or living with diabetes, you can sign up to receive one additional dental cleaning or periodontal maintenance procedure per year.

Dental Plan Limitations and Exclusions

Limitations – Below is a partial listing of dental plan limitations when these services are covered under your plan. Please see your certificate of coverage for a full list.

Diagnostic and Preventive Services

1. **Oral evaluations (exam)**
   Limited to two per Plan Year
2. **Teeth cleaning (prophylaxis)**
   Limited to two per Plan Year
3. **Periapical X-rays, single film**
   Limited to four films per 12-month period
4. **Complete series X-rays**
   (panoramic or full-mouth) Limited to once every 60 months
5. **Topical fluoride application**
   Limited to once every 12 months for members through age 18
6. **Sealants**
   Limited to first and second molars once every 24 months per tooth for members through age 15; sealants may be covered under Diagnostic and Preventive or Basic Services

Basic and/or Major Services**

7. **Fillings**
   Limited to once per surface per tooth in any 24 months
8. **Space Maintainers**
   Limited to extracted primary posterior teeth once per lifetime per tooth for members through age 16; space maintainers may be covered under Diagnostic and Preventive or Basic Services.
9. **Crowns**
   Limited to once per tooth in a seven-year period
10. **Fixed or removable prosthodontics – dentures, partials, bridges**
    Covered once in any seven-year period; benefits are provided for the replacement of an existing bridge, denture or partial for members age 16 or older if the appliance is seven years old or older and cannot be made serviceable.
11. **Root canal therapy**
    Limited to once per lifetime per tooth; coverage is for permanent teeth only.
12. **Periodontal surgery**
    Limited to one complex service per single tooth or quadrant in any 36 months, and only if the pocket depth of the tooth is five millimeters or greater
13. **Periodontal scaling and root planing**
    Limited to once per quadrant in 36 months, when the tooth pocket has a depth of four millimeters or greater
14. **Brush biopsy**
    (Not covered)

ADDITIONAL LIMITATION FOR ORTHODONTIC SERVICES –
if Orthodontia is included as a benefit of your dental plan
Orthodontia Limited to one course of treatment per member per lifetime

Exclusions – Below is a partial listing of noncovered services under your dental plan. Please see your certificate of coverage for a full list.

1. **Services provided before or after the term of this coverage**
   Services received before your effective date or after your coverage ends, unless otherwise specified in the dental plan certificate
2. **Orthodontics (unless included as part of your dental plan benefits)**
   Orthodontic braces, appliances and all related services
3. **Cosmetic dentistry**
   Services provided by dentists solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (cavities) exist
4. **Drugs and medications**
   Intravenous conscious sedation, IV sedation and general anesthesia when performed with nonsurgical dental care
   Analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines or drugs for nonsurgical or surgical dental care except that intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.
5. **Extractions**
   Surgical removal of third molars (wisdom teeth) that do not exhibit symptoms or impact the oral health of the member

**Waiting periods for endodontic, periodontic and oral surgery services may differ from other Basic Services or Major Services under the same dental plan. There may be a waiting period of up to 24 months for replacement of congenitally missing teeth or teeth extracted prior to coverage under this plan.

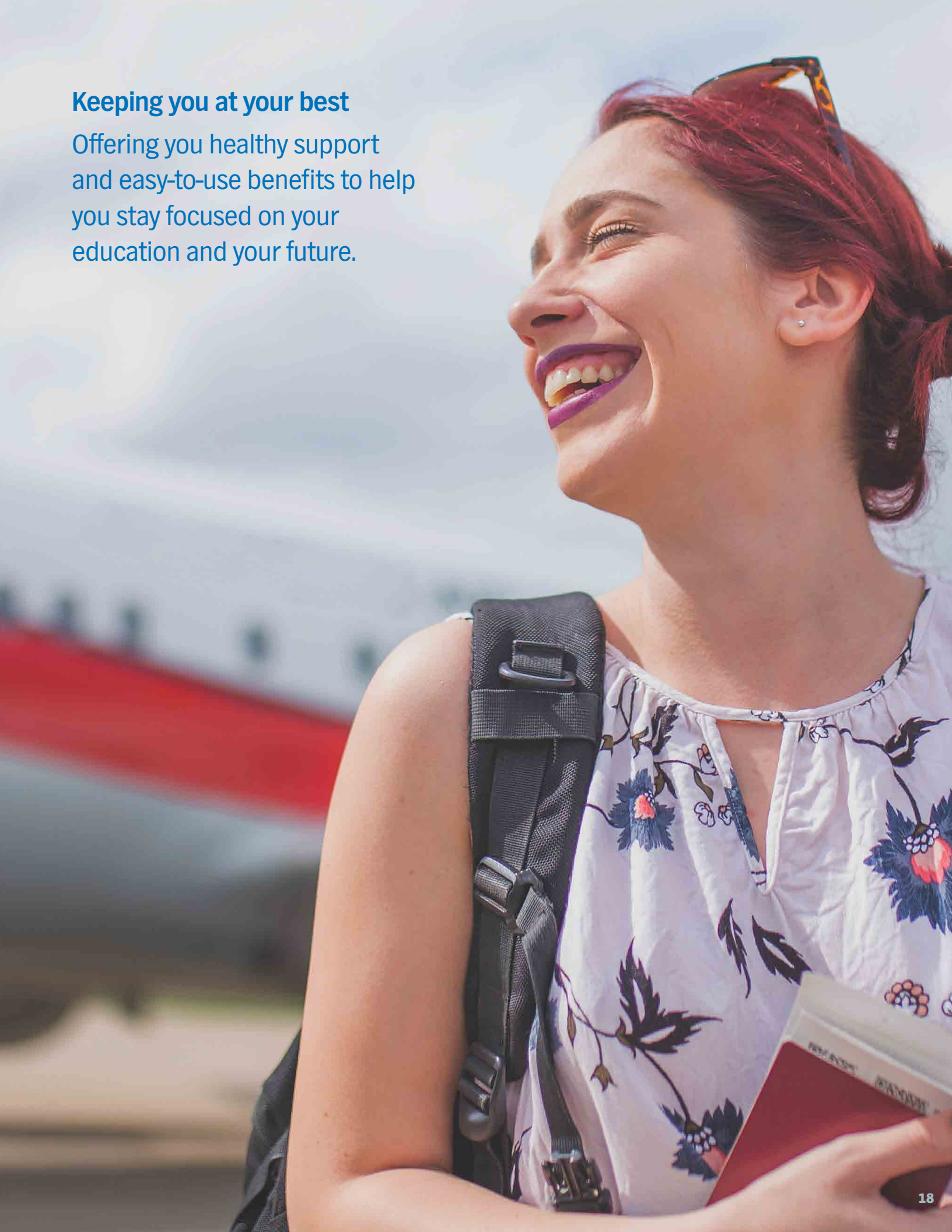
The in-network dental providers mentioned in this communication are independently contracted providers who exercise independent professional judgment. They are not agents or employees of Anthem..

Notes

- All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT} Services)
- Deductible(s) apply to covered medical services listed with a percentage(%) coinsurance, including 0% and to all listed with a copay.
- Dependent age: to end of the month which the child attains age 26
- Specialist copayment is applicable to all Specialists excluding General Physicians, Internist, Pediatricians, OB/GYNs and Geriatrics or any other Network Provider as allowed by the plan.
- When allergy injections are rendered with a Physicians Home and Office Visit, only the Office Visit cost share applies. When the Office Visit cost share is a% coinsurance or a copay, deductible and coinsurance apply to allergy injections. If billed separately, Network Allergy injections are subject to the Allergy Injection $25 copayment.
- Ambulance Non-network non-emergency use limited to $50,000 per benefit period.
- NCS (No Cost Share) means no deductible/co-payment/coinsurance up to the maximum allowable amount.
- PCP is a Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network provider as allowed by the plan.
- SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.
- Live Health Online (LHO) is covered at the PCP costshare.
- Benefit period = plan year
- Prosthetic limbs are unlimited and do not apply to a Plan Lifetime Maximum.
- Mammograms (Diagnostic) are no copaymenl/coinsurance in Network office and outpatient facility settings.
- Behavioral Health Services: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health Parity.
- Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits are no deductible/coinsurance up to the maximum allowable amount.
- Private Duty Nursing - limited to 35 visits per plan year.
- Elective abortions are covered unless otherwise noted in your Certificate of Coverage.

Keeping you at your best

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



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 **1-855-330-1098**.

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 بمقدم خدمات الأعضاء الموجود على بطاقة هويتك الخاصة بك للمساعدة.(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 مربوطه به رایگان به زبان خودتان دریافت کنید. برای کمک دریافت به زبان خود با شماره مرکز تماس اعضاء که روی کارت شناسایی شما درج شده است، 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.

Anthem