2022-2023

Morehouse School of Medicine
Student Health Insurance Plan

www.anthem.com/studentadvantage

Anthem Student Advantage
Keeping you at your personal best

121363XXMENXXX Rev. 07/22

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/studentadvantage.

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 students are automatically enrolled in and charged for the MSM - Sponsored Student Health Insurance Plan unless a waiver or enrollment request is submitted and approved.

To waive online, log onto:
app.hsac.com/msm

Coverage is available for dependents too

If you are covered by Anthem Student Advantage through Morehouse School of Medicine, you may enroll your lawful spouse, domestic partner or dependent children under the age of 26.
Here is how it works:

To enroll eligible dependent(s) of a covered student, please visit:
app.hsac.com/msm/enroll

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

Session	Annual 7/1/22 - 6/30/23	Fall 7/1/22 - 12/31/22	Spring 1/1/23 - 6/30/23
Student Only	$4,850	$2,444.94	$2,405.07
Student + 1 Dependent	$9,700	$4,889.88	$4,810.14
Student + 2 or More Dependents	$14,550	$7,334.82	$7,215.21

*The above rates include premiums for the plan and commissions and administrative fees.
*Rates are pending approval with the state and subject to change.

Keep in touch with your benefits information

Student Health Center

Morehouse School of Medicine Wellness Center
455 Lee Street SW, Third Floor, Ste. 300A
Atlanta, GA 30310
Tel: 1-404-756-1241
Fax: 1-404-756-1237
Email: shwcrequests@msm.edu

shwcrequests@msm.edu

Claims and coverage

1-844-412-0752
Anthem Blue Cross Life and Health Insurance Company
PO Box 105187
Atlanta, GA 30348-5188

Benefits, eligibility and enrollment

HSA Consulting
1-888-978-8355
app.hsac.com/msm

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 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-care/ to find the right doctor or facility close to where you are.

Anthem Student Advantage Morehouse School of Medicine website

Use www.anthem.com/studentadvantage 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:
Morehouse School of Medicine

Your network:
Blue Open Access POS

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
Overall Deductible	$300 person/$600 family	$3,000 person/$9,000 family
Out-of-Pocket Limit	$4,500 person/$9,000 family	$13,500 person/$27,000 family
The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket maximum; in addition, amounts for all covered family members apply to the family deductible and family out-of-pocket maximum. No one member will pay more than the per person deductible or per person out-of-pocket maximum. *All medical and prescription drugs deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services).* *In-network and out-of-network deductibles and out-of-pocket maximum amounts are separate and do not accumulate toward each other.*		
Preventive Care/Screening/Immunization	No charge	30% coinsurance after medical deductible is met
Virtual Care (Telemedicine / Telehealth Visits)		
Virtual Visits with Doctors who also provide services in person Primary Care (PCP)	No charge	40% coinsurance after medical deductible is met
Mental Health and Substance Abuse Care	No charge	40% coinsurance after medical deductible is met
Specialist Care	$50 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Virtual Visits from Online Provider LiveHealth Online *via www.livehealthonline.com; our mobile app, website or Anthem-enabled device*		
Primary Care (PCP) and Mental Health and Substance Abuse Care	No charge for the first 12 visits and then $15 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Specialist Care	$50 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Visits in an Office		
Primary Care (PCP)	No charge	40% coinsurance after medical deductible is met
Specialist Care	$50 copay per visit, medical deductible does not apply	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal) *In-Network routine prenatal office visits and other preventive prenatal care and screening are covered at 100%.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Retail Health Clinic	No charge	40% coinsurance after medical deductible is met
Chiropractic/Manipulation Therapy *Coverage is limited to 20 visits per year. Limit is combined In-Network and Non-Network. Limits is combined across professional visits and outpatient facilities*	$25 copay per visit, medical deductible does not apply	40% coinsurance after medical deductible is met
Acupuncture	Not covered	Not covered
Other Services in an Office		
Allergy Testing	No charge or $50 copay if preformed in a specialist office. Medical deductible does not apply	40% coinsurance after medical deductible is met
Chemo/Radiation Therapy *State Mandate: Cost share cannot exceed $200 per filled prescription for any orally administered chemotherapy drug.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Dialysis/Hemodialysis	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Prescription Drugs - *Dispensed in the office*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Surgery	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Diagnostic Services		
Lab		
Office *All services performed in the office are included in the office copay.*	No charge or $50 copay if preformed in a specialist office. Medical deductible does not apply	40% coinsurance after medical deductible is met
Freestanding Lab/Reference Lab	No charge	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
X-Ray		
Office *All services performed in the office are included in the office copay.*	No charge or $50 copay if performed in a specialist office. Medical deductible does not apply.	40% coinsurance after medical deductible is met
Freestanding Radiology Center	20% coinsurance. Medical deductible does not apply.	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Advanced Diagnostic Imaging (MRI/PET/CAT scans)		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Freestanding Radiology Center	20% coinsurance. Medical deductible does not apply	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Emergency and Urgent Care		
Urgent Care	$60 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Emergency Room Facility Services *Copay waived if admitted. Non-emergency use of Emergency Room Services is Not Covered.*	$150 copay per visit and 20% coinsurance medical deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after medical deductible is met	Covered as In-Network
Emergency Ambulance	20% coinsurance after medical deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	No charge	40% coinsurance after medical deductible is met
Facility visit: Facility Fees	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Doctor Services	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Surgery		
Facility Fees Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Freestanding Surgical Center	$150 copay per visit and 20% coinsurance. Medical deductible does not apply	40% coinsurance after medical deductible is met
Doctor and Other Services Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Freestanding Surgical Center	20% coinsurance, deductible does not apply.	40% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse)		
Facility fees *Coverage for Inpatient Rehabilitation and Skilled Nursing services is limited to 60 days combined per year. Limit is combined In-Network and Non-Network.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Human Organ and Tissue Transplants *Coverage includes acquisition and transplant procedures, collection and storage.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Doctor and other services	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 120 visits per year. Limit is combined In-Network and Non-Network. Limit does not apply to separate Physical or Occupational or Speech Therapy limits, when performed as part of Home Health. Limits are combined for home health care and private duty nursing.*	$25 copay per visit medical deductible does not apply.	40% coinsurance after medical deductible is met
Rehabilitation services *Coverage for speech therapy is limited to 20 visits per year. Limits is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.* *Coverage for rehabilitative physical therapy and occupational therapy combined is limited to 20 visits per year. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*		
Office	$25 copay per visit medical deductible does not apply.	40% coinsurance after medical deductible is met
Outpatient Hospital Limits are combined with rehabilitation office visits.	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Habilitation services *Coverage for speech therapy is limited to 20 visits per year. Coverage for habilitative physical therapy and occupational therapy combined is limited to 20 visits per year. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*		
Office	$25 copay per visit medical deductible does not apply.	40% coinsurance after medical deductible is met
Outpatient Hospital Limits are combined with rehabilitation office visits.	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Cardiac rehabilitation		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Skilled Nursing Care (facility) *Coverage for Inpatient Rehabilitation and Skilled Nursing services is limited to 60 days combined per year. Limit is combined In-Network and Non-Network*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Inpatient Hospice	0% coinsurance medical deductible does not apply	40% coinsurance after medical deductible is met
Durable Medical Equipment *Coverage for hearing aids services is limited to 1 item per hearing-impaired ear every 48 months. Covered through the age of 18 years of age. Limited to $3,000 maximum per hearing aid. Limit is combined In-Network and Non-Network.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per year. Limit is combined In-Network and Non-Network.*	20% coinsurance after medical deductible is met	40% coinsurance after medical 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 LImit	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
Prescription Drug Coverage *Cost shares for drugs included on the Traditional Open drug list appear below. Your plan uses the Base Network. You may receive up to a 90 day supply of medication at Retail 90 pharmacies.*		
Tier 1 - Typically Generic *Covers up to a 90 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).*	Tier 1 - $15 copay per prescription, deductible does not apply (retail and home delivery)	Tier 1 - $15 copay per prescription, deductible does not apply (retail only)
Tier 2 – Typically Preferred Brand *Covers up to a 90 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).*	Tier 2 - $35 copay per prescription, deductible does not apply (retail) and $70 copay per prescription, deductible does not apply (home delivery)	Tier 2 - $35 copay per prescription, deductible does not apply (retail only)
Tier 3 - Typically Non-Preferred Brand *Covers up to a 90 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).*	Tier 3 - $60 copay per prescription, deductible does not apply (retail) and $180 copay per prescription, deductible does not apply (home delivery)	Tier 3- $60 copay per prescription, deductible does not apply (retail only)
Tier 4 – Typically Specialty (brand and generic) *Per 30 day supply (specialty pharmacy).*	20% coinsurance up to $300 per prescription, deductible does not apply (retail and home delivery)	20% coinsurance up to $300 per prescription, deductible does not apply (retail only)

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. Only children's vision services count towards your out of pocket limit.		
Children's Vision Essential Health Benefits (up to age 19)		
Vision exam *Limited to 1 exam per benefit period.*	No charge	Reimbursed Up to $30
Frames *Limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $45
Lenses *Limited to 1 unit per benefit period combined with OON Coverage. OON Reimbursement: Single Reimbursed Up to $25, Bifocal Reimbursed Up to $40, Trifocal Reimbursed Up to $55.*	No charge	Receives Reimbursement
Elective Contact Lenses *Limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $60
Non-Elective Contact Lenses *Limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $210

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. Only children's dental services count towards your out of pocket limit.		
Children's Dental Essential Health Benefits (up to age 19)		
Diagnostic and preventive *Limited to 2 visits per Benefit Period.*	No charge	No charge
Basic services	20% coinsurance	20% coinsurance
Major services	50% coinsurance	50% coinsurance
Medically Necessary Orthodontia services	50% coinsurance	50% coinsurance
Cosmetic Orthodontia services	Not covered	Not covered
Deductible	Not applicable	Not applicable
Adult Dental	Not covered	Not covered

Benefits that go with you

You can count on medical coverage anywhere worldwide with GeoBlue.[1] Easily access international doctors by phone or video and use our 24/7 help center for emergency health questions. Anthem Student Advantage and GeoBlue provides the right support and services when you need them the most.

Visit https://www.geobluestudents.com to learn more.

GeoBlue benefits for the 2022-2023 school year

Use of benefits must be coordinated and approved by GeoBlue.

International telemedicine services[2]	
Global TeleMD™	Confidential access to international doctors by telephone or video call.
Coverage outside the U.S., excluding student's home country.	
Medical Expenses	Maximum benefit up to $250,000 per coverage year, no deductibles or copays. Consult coverage certificate for benefit limitations and exclusions.[3]
Coverage worldwide except within 100 miles of primary residence for U.S. students. Coverage worldwide, excluding home country for international students.	
Emergency medical evacuation	Unlimited
Repatriation of remains	Unlimited
Emergency family travel arrangements	Maximum benefit up to $5,000 per coverage year
Political emergency and natural disaster evacuation (Available only when traveling outside the United States)[4]	Covered 100% up to $100,000 per person. Subject to a combined $5,000,000 limit per any one covered event for all people covered under the plan.
Accidental death and dismemberment	Maximum benefit up to $10,000 per coverage year

GeoBlue

1 GeoBlue is the trade name of Worldwide Insurance Services, LLC (Worldwide Services Insurance Agency, LLC in California and New York), an independent licensee of the Blue Cross and Blue Shield Association. GeoBlue is the administrator of coverage provided under insurance policies issued by 4 Ever Life International Limited, Bermuda, an independent licensee of the Blue Cross Blue Shield Association. Coverage is not available in all states. Some restrictions apply.

2 Telemedicine services are provided by Teladoc Health, directly to members. GeoBlue assumes no liability and accepts no responsibility for information provided by Teladoc Health and the performance of the services by Teladoc Health. Support and information provided through this service does not confirm that any related treatment or additional support is covered under a member's health plan.

3 These medical expenses are limited and are subject to limitations and exclusions. See full certificate of insurance for a full description of services and coverage of what is and isn't covered.

4 The Political, Military and Natural Disaster Evacuation Services (PEND) are provided through Crisis24, an independent third party, non-affiliated service provider. Crisis24 does not supply Blue Cross or Blue Shield products or other benefits, and is therefore solely responsible for PEND and other collateral services it provides. GeoBlue makes no warranty, express or implied, and accepts no responsibility resulting from the provision or use of Crisis24 PEND or other Crisis24 services.

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

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

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 Certificate of Coverage. If there is a difference between this summary and the Certificate of Coverage the Certificate of Coverage will prevail.

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

ىلع دوجوملا ءاضعلأا تامدخ مقرب لصتا .ًاناجم كتغلب ةدعاسملاو تامولعملا هذه ىلع لوصحلا كل قحي ةقاطب فيرعتلا ةصاخلا كب ةدعاسملل.(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

تروصب ار اهکمک و تاعلاطا نیا هک دیراد ار قح نیا امش هب کمک تفایرد یارب .دینک تفایرد ناتدوخ نابز هب ناگیار جرد ناتییاسانش تراک یور رب هک ءاضعا تامدخ زکرم هرامش دیریگب سامت ،تسا .(TTY/TDD: 711) هدش

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' áajį' 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

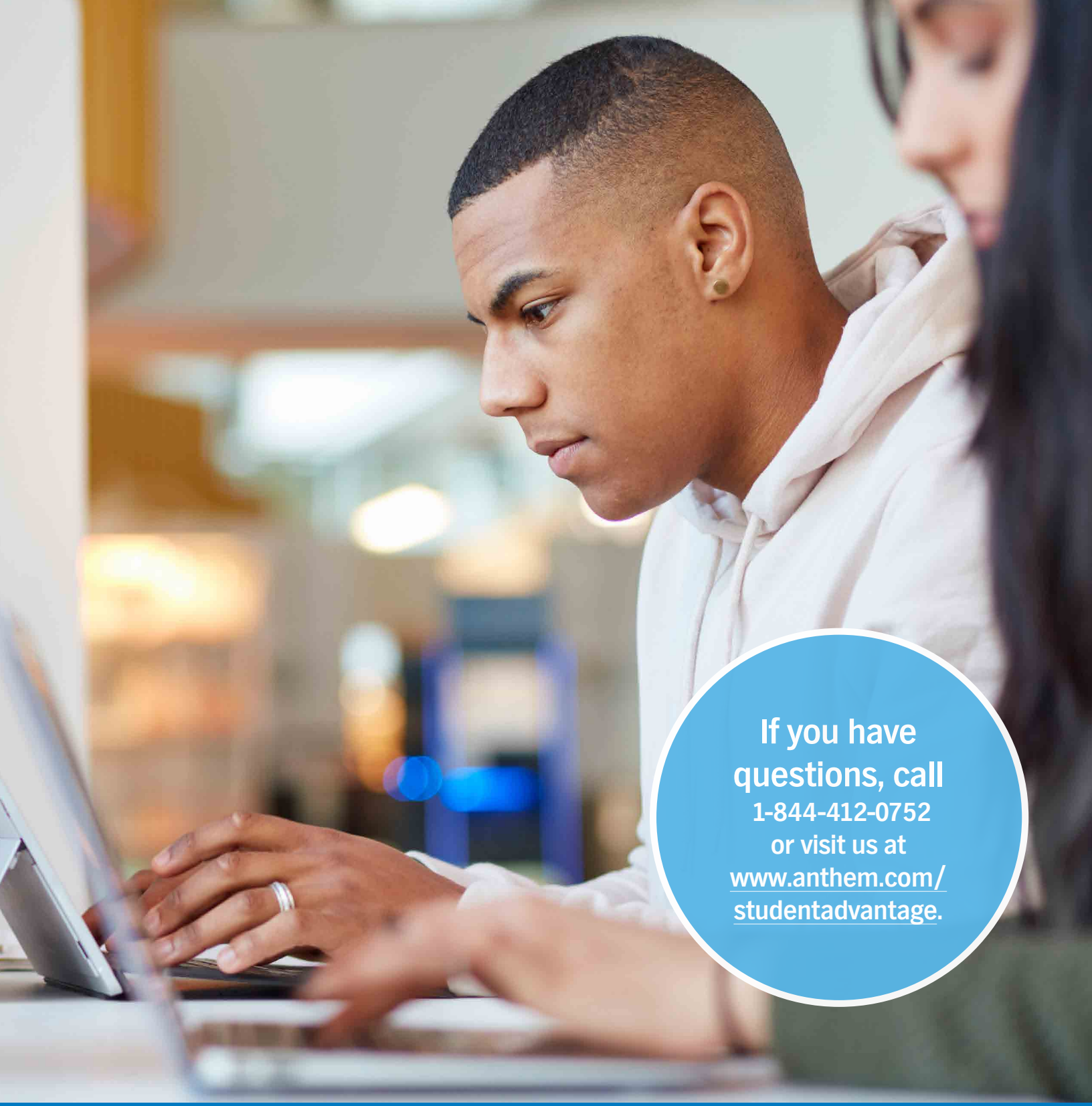
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

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.



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