

Your summary of benefits

Anthem® Blue Cross

Your Plan: Anthem PPO HSA-H 2000/2800/4000 20/40

Your Network: Prudent Buyer 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.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible <i>See notes section to understand how your deductible works.</i>	\$2,000 individual \$2,800 member / \$4,000 family	\$6,000 individual \$6,000 member / \$12,000 family
Out-of-Pocket Limit <i>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.</i>	\$3,000 individual \$3,000 member / \$6,000 family	\$9,000 individual \$9,000 member / \$18,000 family
Preventive care/screening/immunization <i>In-network preventive care is not subject to deductible, if your plan has a deductible.</i>	No charge	40% coinsurance after deductible is met
Doctor Home and Office Services Primary Care Visit to treat an injury or illness	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Specialist Care Visit	20% coinsurance after deductible is met	40% coinsurance after deductible is met

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<p>Prenatal and Post-natal Care</p>	<p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p>
<p>Other Practitioner Visits:</p> <p>Retail Health Clinic</p> <p>Preferred On-line Visit <i>Includes Mental/ Behavioral Health and Substance Abuse</i></p> <p>Chiropractic Services <i>Coverage is limited to 30 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings. Visit limits are combined both across outpatient and other professional visits.</i></p> <p>Acupuncture <i>Coverage is limited to 20 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.</i></p>	<p>20% coinsurance after deductible is met</p> <p>\$10 copay after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>Not covered</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p>Other Services in an Office:</p> <p>Allergy Testing</p> <p>Chemo/Radiation Therapy</p> <p>Hemodialysis <i>Anthem's maximum payment is up to \$350 per visit for Non-Network Providers.</i></p> <p>Prescription Drugs <i>For the drugs itself dispensed in the office through infusion/ injection.</i></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>

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<p>Diagnostic Services</p> <p>Lab:</p> <p>Office</p> <p>Freestanding Lab</p> <p>Outpatient Hospital <i>Anthem's maximum payment is up to \$350 per service for Non-Network Providers.</i></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p>X-Ray:</p> <p>Office</p> <p>Freestanding Radiology Center</p> <p>Outpatient Hospital <i>Anthem's maximum payment is up to \$350 per visit for Non-Network Providers.</i></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p>Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):</p> <p>Office <i>Anthem's maximum payment is up to \$800 per service for Non-Network Providers.</i></p> <p>Freestanding Radiology Center <i>Anthem's maximum payment is up to \$800 per service for non-network providers.</i></p> <p>Outpatient Hospital <i>Anthem's maximum payment is up to \$800 per service for non-network providers.</i></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>

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Emergency and Urgent Care Urgent Care (Office Setting)	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Emergency Room Facility Services Emergency Room Doctor and Other Services	20% coinsurance after deductible is met	Covered as In-Network
Ambulance (Air and Ground)	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse Doctor Office Visit Facility visit: Facility Fees Doctor Services	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met
Outpatient Surgery Facility Fees: Hospital <i>Anthem's maximum payment is up to \$350 per service for Non-Network Providers.</i> Freestanding Surgical Center <i>Anthem's maximum payment is up to \$350 per service for Non-Network Providers.</i>	20% coinsurance after deductible is met 20% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>Doctor and Other Services:</p> <p>Hospital/Freestanding Surgical Center</p>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<p>Hospital Stay (all inpatient stays including Maternity, Mental / Behavioral Health, and Substance Abuse)</p> <p>Facility fees (for example, room & board) <i>Anthem's maximum payment is up to \$1,000 per day for non-emergency admissions to non-network providers.</i></p> <p>Doctor and other services</p>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<p>Recovery & Rehabilitation</p> <p>Home Health Care <i>Coverage is limited to 100 visits per benefit period. Limit is combined In-Network and Non-Network.</i></p>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<p>Rehabilitation services (for example, physical/speech/occupational therapy):</p> <p>Office <i>Costs may vary by site of service.</i></p> <p>Outpatient Hospital <i>Anthem's maximum payment is up to \$350 per visit for Non-Network Providers.</i></p>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<p>Habilitation services (for example, physical/speech/occupational therapy):</p> <p>Office <i>Costs may vary by site of service.</i></p> <p>Outpatient Hospital <i>Anthem's maximum payment is up to \$350 per visit for Non-Network Providers.</i></p>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<p>Cardiac rehabilitation</p>		

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Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital <i>Anthem's maximum payment is up to \$350 per visit for Non-Network Providers.</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Skilled Nursing Care (in a facility) <i>Coverage is limited to 100 days per benefit period. Limit is combined In-Network and Non-Network.</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Hospice	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Durable Medical Equipment	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices	20% coinsurance after deductible is met	40% coinsurance after deductible is met

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Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Combined with medical deductible	Combined with medical deductible
Pharmacy Out of Pocket	Combined with medical out of pocket maximum	Combined with medical out of pocket maximum
Prescription Drug Coverage <i>This plan uses an Essential Drug List. Drugs not on the list are not covered. This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies.</i>		
Preventive Drugs <i>Preventive Rx Plus: Deductible is waived for certain drugs for diabetes, asthma, heart health, high blood pressure, high cholesterol, stroke, and osteoporosis.</i> Tier 1a - Typically Lower Cost Generic Tier 1b – Typically Generic Tier 2 - Typically Preferred Brand	No charge No charge No charge	40% coinsurance up to \$250 per prescription after deductible is met (retail) and Not covered (home delivery)
Tier 1a - Typically Lower Cost Generic <i>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). You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. No coverage for non-formulary drugs.</i> Tier 1b - Typically Generic <i>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). You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. No coverage for non-formulary drugs.</i>	\$5 copay per prescription after deductible is met (retail) and \$12.50 copay per prescription after deductible is met (home delivery) \$15 copay per prescription after deductible is met (retail) and \$37.50 copay per	40% coinsurance up to \$250 per prescription after deductible is met (retail) and Not covered (home delivery) 40% coinsurance up to \$250 per prescription after deductible is met (retail) and Not

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
	prescription after deductible is met (home delivery)	covered (home delivery)
<p>Tier 2 – Typically Preferred Brand <i>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). You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. No coverage for non-formulary drugs.</i></p>	\$40 copay per prescription after deductible is met (retail) and \$120 copay per prescription after deductible is met (home delivery)	40% coinsurance up to \$250 per prescription after deductible is met (retail) and Not covered (home delivery)
<p>Tier 3 - Typically Non-Preferred Brand <i>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). You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. No coverage for non-formulary drugs.</i></p>	\$60 copay per prescription after deductible is met (retail) and \$180 copay per prescription after deductible is met (home delivery)	40% coinsurance up to \$250 per prescription after deductible is met (retail) and Not covered (home delivery)
<p>Tier 4 - Typically Specialty (brand and generic) <i>Covers up to a 30 day supply (retail pharmacy). Classified specialty drugs must be obtained through our Specialty Pharmacy Program and are subject to the terms of the program. No coverage for non-formulary drugs.</i></p>	30% coinsurance up to \$250 per prescription after deductible is met (retail and home delivery)	40% coinsurance up to \$250 per prescription after deductible is met (retail) and Not covered (home delivery)

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Notes:

- The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, 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.
- In network and out of network deductible and out of pocket maximum are exclusive of each other.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- For additional information on this plan, please visit www.sbc.anthem.com to obtain a “Summary of Benefits and Coverage”.
- Pharmacy deductible and pharmacy out of pocket is combined with medical deductible and out-of-pocket.
- 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.
- If your plan includes out of network benefit and you use a non-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.
- Bariatric Surgery covered only when performed at Blue Distinction Center for Specialty Care for Bariatric Surgery.
- 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 (i.e., X-ray, lab, surgery), after any applicable deductible.
- Transplants covered only when performed at Centers of Medical Excellence or Blue Distinction Centers.
- All medical services subject to a coinsurance are also subject to the annual medical deductible.
- Annual Out-of-Pocket Maximums includes deductible, copays, coinsurance and prescription drug.
- Members over 18 years of age are eligible to earn additional HRA credits for each Total Rewards incentive program per calendar year.
- Certain drugs require pre-authorization approval to obtain coverage.
- 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.
- 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.
- 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.
- Freestanding Lab and Radiology Center is defined as services received in a non-hospital based facility.

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Questions: (855) 333-5730 or visit us at www.anthem.com/ca

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- 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 California 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.
- Preventive Care Services includes 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.
- Respite Care limited to 5 visits per lifetime.
- Skilled Nursing Facility day limit does not apply to mental health and substance abuse.
- Supply limits for certain drugs may be different, go to Anthem website or call customer service.
- This Summary of Benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently 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 California Department of Insurance and the California Department of Managed Health Care (as applicable).
- For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to https://le.anthem.com/pdf?x=CA_LG_CDHP.
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.

Get help in your language

Language Assistance Services



Curious to know what all this says? We would be too. Here's the English version:

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (TTY/TDD: 711)

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.

Spanish

IMPORTANTE: ¿Puede leer esta carta? De lo contrario, podemos hacer que alguien lo ayude a leerla. También puede recibir esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721. (TTY/TDD: 711)

Arabic

مهم: هل يمكنك قراءة هذه الرسالة؟ إذا لم تستطع، فيمكننا الاستعانة بشخص ما ليساعدك على قراءتها. كما يمكنك أيضًا الحصول على هذا الخطاب مكتوبًا بلغتك. للحصول على المساعدة المجانية، يُرجى الاتصال فورًا بالرقم 1-888-254-2721 (TTY/TDD: 711).

Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք ընթերցել այս նամակը: Եթե ոչ, մենք կարող ենք տրամադրել ինչ-որ մեկին, ով կօգնի Ձեզ՝ կարդալ այն: Կարող ենք նաև այս նամակը Ձեզ գրավոր տարբերակով տրամադրել: Անվճար օգնություն ստանալու համար կարող եք անհապաղ զանգահարել 1-888-254-2721 հեռախոսահամարով: (TTY/TDD: 711)

Chinese

重要事項：您能看懂這封信函嗎？如果您看不懂，我們能夠找人協助您。您有可能可以獲得以您的語言而寫的本信函。如需免費協助，請立即撥打1-888-254-2721。(TTY/TDD: 711)

Farsi

مهم: آیا می‌توانید این نامه را بخوانید؟ اگر نمی‌توانید، می‌توانیم شخصی را به شما معرفی کنیم تا در خواندن این نامه شما را کمک کند. همچنین می‌توانید این نامه را به صورت مکتوب به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، همین حالا با شماره 1-888-254-2721 تماس بگیرید. (TTY/TDD: 711)

Hindi

महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? अगर नहीं, तो हम आपको इसे पढ़ने में मदद करने के लिए किसी को उपलब्ध करा सकते हैं। आप यह पत्र अपनी भाषा में लिखवाने में भी सक्षम हो सकते हैं। निःशुल्क मदद के लिए, कृपया 1-888-254-2721 पर तुरंत कॉल करें। (TTY/TDD: 711)

Hmong

TSEEM CEEB: Koj puas muaj peev xwm nyeem tau daim ntawv no? Yog hais tias koj nyeem tsis tau, peb muaj peev xwm cia lwm tus pab nyeem rau koj mloog. Tsis tas li ntawd tej zaum koj kuj tseem yuav tau txais daim ntawv no sau ua koj hom lus thiab. Txog rau kev pab dawb, thov hu tam sim no rau tus xov tooj 1-888-254-2721. (TTY/TDD: 711)

Japanese

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重要：この書簡を読めますか？もし読めない場合には、内容を理解するための支援を受けることができます。また、この書簡を希望する言語で書いたものを入手することもできます。次の番号にいますぐ電話して、無料支援を受けてください。
1-888-254-2721 (TTY/TDD: 711)

Khmer
សំខាន់៖ តើអ្នកអាចអានលិខិតនេះទេ? បើមិនអាចទេ យើងអាចឱ្យនិយោជករបស់យើងជួយអ្នក។ អ្នកក៏អាចទទួលបានលិខិតនេះដោយសេរីជាភាសាបស់អ្នកផងដែរ។ ដើម្បីទទួលបានជំនួយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅលេខ 1-888-254-2721។ (TTY/TDD: 711)

Korean
중요: 이 서신을 읽으실 수 있으십니까? 읽으실 수 없을 경우 도움을 드릴 사람이 있습니다. 귀하가 사용하는 언어로 쓰여진 서신을 받으실 수도 있습니다. 무료 도움을 받으시려면 즉시 1-888-254-2721로 전화하십시오. (TTY/TDD: 711)

Punjabi
ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹ ਤਾਂ ਅਸ ਇਸ ਨੂੰ ਪੜ੍ਹ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਕਿਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸ ਸ਼ਾਇਦ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵੱਖੀ ਪੜ੍ਹਾ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਫੋਨ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Russian
ВАЖНО. Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по номеру 1-888-254-2721. (TTY/TDD: 711)

Tagalog
MAHALAGA: Nababasa ba ninyo ang liham na ito? Kung hindi, may taong maaaring tumulong sa inyo sa pagbasa nito. Maaari ninyo ring makuha ang liham na ito nang nakasulat sa ginagamit ninyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

Thai
หมายเหตุสำคัญ: ท่านสามารถอ่านจดหมายฉบับนี้หรือไม่ หากท่านไม่สามารถอ่านจดหมายฉบับนี้ เราสามารถจัดหาเจ้าหน้าที่มาอ่านให้ท่านฟังได้ ท่านยังอาจให้เจ้าหน้าที่ช่วยเขียนจดหมายในภาษาของท่านอีกด้วย หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดโทรติดต่อที่หมายเลข 1-888-254-2721 (TTY/TDD: 711)

Vietnamese
QUAN TRỌNG: Quý vị có thể đọc thư này hay không? Nếu không, chúng tôi có thể bố trí người giúp quý vị đọc thư này. Quý vị cũng có thể nhận thư này bằng ngôn ngữ của quý vị. Để được giúp đỡ miễn phí, vui lòng gọi ngay số 1-888-254-2721. (TTY/TDD: 711)

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence

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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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