



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-855-609-5684 or at <https://policy-srv.box.com/s/9blxu50jh5kv1rrciyck8um9881f0syu>.

For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call 1-855-756-4448 to request a copy.

| Important Questions                                                 | Answers                                                                                                                     | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <u>deductible</u> ?                             | \$0                                                                                                                         | See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Are there services covered before you meet your <u>deductible</u> ? | No.                                                                                                                         | You will have to meet the <u>deductible</u> before the <u>plan</u> pays for any services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Are there other <u>deductibles</u> for specific services?           | No.                                                                                                                         | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?       | \$4,000 Individual / \$12,000 Family                                                                                        | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.                                                                                                                                                                                                                                                                                     |
| What is not included in the <u>out-of-pocket limit</u> ?            | <u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.                           | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Will you pay less if you use a <u>network provider</u> ?            | Yes. See <a href="http://www.bcbsok.com">www.bcbsok.com</a> or call 1-855-609-5684 for a list of <u>network providers</u> . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u> ?          | No.                                                                                                                         | You can see the <u>specialist</u> you choose without a <u>referral</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |

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

| Common Medical Event                                                                                                                                                                                                                                                                                                                                                  | Services You May Need                            | What You Will Pay                            |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------|----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                                                                       |                                                  | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>If you visit a health care provider's office or clinic</b>                                                                                                                                                                                                                                                                                                         | Primary care visit to treat an injury or illness | \$25/visit                                   | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                       | <u>Specialist</u> visit                          | \$50/visit                                   | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                       | Preventive care/screening/immunization           | No Charge                                    | Not Covered                                        | You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>If you have a test</b>                                                                                                                                                                                                                                                                                                                                             | <u>Diagnostic test</u> (x-ray, blood work)       | \$25/test                                    | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                       | Imaging (CT/PET scans, MRIs)                     | \$250/scan                                   | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <b>prescription drug coverage</b> is available at <a href="https://www.bcbsok.com/member/prescription-drug-plan-information/pharmacy-prescription-plan-information">https://www.bcbsok.com/member/prescription-drug-plan-information/pharmacy-prescription-plan-information</a> | Preferred generic drugs                          | \$5 retail<br>\$10 mail order/prescription   | Not Covered                                        | Limited to a 30-day supply at retail (or a 90-day supply at a network of select retail pharmacies). Up to 90-day supply at mail order.<br><br>Payment of the difference between the cost of a brand name drug and a generic may be required if a generic drug is available. <u>Specialty drugs</u> must be obtained from <u>Network specialty pharmacy provider</u> . -day supply except for certain FDA-designated dosing regimens. Mail order is not covered. Your cost for a covered insulin drug will not exceed \$30 per 30-day supply or \$90 per 90-day supply. |
|                                                                                                                                                                                                                                                                                                                                                                       | Non-preferred generic drugs                      | \$15 retail<br>\$30 mail order/prescription  | Not Covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                                                                                                                                                                                                                                                                                                                       | Preferred brand drugs                            | \$40 retail<br>\$80 mail order/prescription  | Not Covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                                                                                                                                                                                                                                                                                                                       | Non-preferred brand drugs                        | \$80 retail<br>\$160 mail order/prescription | Not Covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                                                                                                                                                                                                                                                                                                                       | Preferred <u>specialty drugs</u>                 | \$100/prescription                           | Not Covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                                                                                                                                                                                                                                                                                                                       | Non-preferred <u>specialty drugs</u>             | \$200/prescription                           | Not Covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>If you have outpatient surgery</b>                                                                                                                                                                                                                                                                                                                                 | Facility fee (e.g., ambulatory surgery center)   | \$750/visit                                  | Not Covered                                        | Elective abortion is not covered. <u>Preauthorization</u> required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                                                                                                                                                                       | Physician/surgeon fees                           | No Charge                                    | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |

\* For more information about limitations and exceptions, see the plan or policy document at <https://policy-srv.box.com/s/9blxu50jh5kv1rrciyck8um9881f0syu>.

| Common Medical Event                                                             | Services You May Need                     | What You Will Pay                                                      |                                                                        | Limitations, Exceptions, & Other Important Information                                                                                                                                                                               |
|----------------------------------------------------------------------------------|-------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                  |                                           | Network Provider<br>(You will pay the least)                           | Out-of-Network Provider<br>(You will pay the most)                     |                                                                                                                                                                                                                                      |
| <b>If you need immediate medical attention</b>                                   | <u>Emergency room care</u>                | Facility Charges:<br>\$300/visit<br>ER Physician Charges:<br>No Charge | Facility Charges:<br>\$300/visit<br>ER Physician Charges:<br>No Charge | <u>Copayment</u> waived if admitted.                                                                                                                                                                                                 |
|                                                                                  | <u>Emergency medical transportation</u>   | No Charge                                                              | No Charge                                                              | Ground and air transportation covered.                                                                                                                                                                                               |
|                                                                                  | <u>Urgent care</u>                        | \$50/visit                                                             | Not Covered                                                            | None                                                                                                                                                                                                                                 |
| <b>If you have a hospital stay</b>                                               | Facility fee (e.g., hospital room)        | \$1,000/day                                                            | Not Covered                                                            | <u>Preauthorization</u> required. \$1,000 <u>copayment</u> per day for the first 3 days per benefit period.                                                                                                                          |
|                                                                                  | Physician/surgeon fees                    | No Charge                                                              | Not Covered                                                            | None                                                                                                                                                                                                                                 |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | \$25 PCP / \$50 SPC/visit                                              | Not Covered                                                            | <u>Preauthorization</u> required for certain services.                                                                                                                                                                               |
|                                                                                  | Inpatient services                        | \$1,000/day                                                            | Not Covered                                                            | <u>Preauthorization</u> required. \$1,000 <u>copayment</u> per day for the first 3 days per benefit period.                                                                                                                          |
| <b>If you are pregnant</b>                                                       | Office visits                             | No Charge                                                              | Not Covered                                                            | <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
|                                                                                  | Childbirth/delivery professional services | No Charge                                                              | Not Covered                                                            |                                                                                                                                                                                                                                      |
|                                                                                  | Childbirth/delivery facility services     | \$2,000/admission                                                      | Not Covered                                                            | <u>Preauthorization</u> required.                                                                                                                                                                                                    |
| <b>If you need help recovering or have other special health needs</b>            | <u>Home health care</u>                   | No Charge                                                              | Not Covered                                                            | <u>Preauthorization</u> required.                                                                                                                                                                                                    |
|                                                                                  | <u>Rehabilitation services</u>            | \$25 PCP / \$50 SPC/visit                                              | Not Covered                                                            | Outpatient: Combined 60 visit limit per benefit period for physical, speech, and occupational therapies.                                                                                                                             |
|                                                                                  | <u>Habilitation services</u>              | \$25 PCP / \$50 SPC/visit                                              | Not Covered                                                            |                                                                                                                                                                                                                                      |
|                                                                                  | <u>Skilled nursing care</u>               | \$100/day                                                              | Not Covered                                                            | <u>Preauthorization</u> required. \$100 <u>copayment</u> per day for the first 8 days per benefit period.                                                                                                                            |
|                                                                                  | <u>Durable medical equipment</u>          | 20% <u>coinsurance</u>                                                 | Not Covered                                                            | <u>Medically necessary</u> , rental or purchase at the <u>plan's</u> discretion.                                                                                                                                                     |
|                                                                                  | <u>Hospice services</u>                   | No Charge                                                              | Not Covered                                                            | <u>Preauthorization</u> required.                                                                                                                                                                                                    |
| <b>If your child needs dental or eye care</b>                                    | Children's eye exam                       | \$25 PCP / \$50 SPC/visit                                              | Not Covered                                                            | Limited to 1 visit per calendar year.                                                                                                                                                                                                |
|                                                                                  | Children's glasses                        | Not Covered                                                            | Not Covered                                                            | None                                                                                                                                                                                                                                 |
|                                                                                  | Children's dental check-up                | Not Covered                                                            | Not Covered                                                            | None                                                                                                                                                                                                                                 |

## Excluded Services & Other Covered Services:

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

- |                                                                                                                   |                                                                                                                    |                                                                                                                                                                 |
|-------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>• Acupuncture</li><li>• Cosmetic surgery</li><li>• Custodial care</li></ul> | <ul style="list-style-type: none"><li>• Dental care</li><li>• Elective abortion</li><li>• Long-term care</li></ul> | <ul style="list-style-type: none"><li>• Non-emergency care when traveling outside the U.S.</li><li>• Routine foot care</li><li>• Weight loss programs</li></ul> |
|-------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|

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

- |                                                                                                 |                                                                                                                                |                                                                                                           |
|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>• Bariatric surgery</li><li>• Chiropractic care</li></ul> | <ul style="list-style-type: none"><li>• Hearing aids (1 per ear per 48-month period)</li><li>• Infertility treatment</li></ul> | <ul style="list-style-type: none"><li>• Private-duty nursing</li><li>• Routine eye care (Adult)</li></ul> |
|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: For group health coverage contact the plan, Blue Cross and Blue Shield of Oklahoma at 1-855-609-5684 or visit [www.bcbsok.com](http://www.bcbsok.com). For group health coverage subject to ERISA, contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). For non-federal governmental group health plans, contact Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: For group health coverage subject to ERISA: Blue Cross and Blue Shield of Oklahoma at 1-855-609-5684 or visit [www.bcbsok.com](http://www.bcbsok.com), the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), and the Oklahoma Department of Insurance, Consumer Protection at 1-800-522-0071 or [www.oid.ok.gov](http://www.oid.ok.gov). For non-federal governmental group health plans and church plans that are group health plans, Blue Cross and Blue Shield of Oklahoma at 1-855-609-5684 or visit [www.bcbsok.com](http://www.bcbsok.com) or contact the Oklahoma Department of Insurance, Consumer Protection at 1-405-521-2991 or [www.oid.ok.gov](http://www.oid.ok.gov). Additionally, a consumer assistance program can help you file your appeal. Contact the Oklahoma Department of Insurance's Consumer Health Assistance Program at 1-405-521-2991 or visit [www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/ok.html](http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/ok.html).

**Does this plan provide Minimum Essential Coverage? Yes.**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet the Minimum Value Standards? Yes.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-609-5684.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-609-5684.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-609-5684.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-609-5684.

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

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

|                                               |         |
|-----------------------------------------------|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$0     |
| ■ <u>Specialist copayment</u>                 | \$50    |
| ■ Hospital (facility) <u>copayment</u>        | \$1,000 |
| ■ Other <u>coinsurance</u>                    | 0%      |

#### This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
Diagnostic tests (*ultrasounds and blood work*)  
Specialist visit (*anesthesia*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

#### In this example, Peg would pay:

| <i>Cost Sharing</i> |         |
|---------------------|---------|
| <u>Deductibles</u>  | \$0     |
| <u>Copayments</u>   | \$1,700 |
| <u>Coinsurance</u>  | \$0     |

#### *What isn't covered*

|                                   |                |
|-----------------------------------|----------------|
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$1,760</b> |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                               |         |
|-----------------------------------------------|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$0     |
| ■ <u>Specialist copayment</u>                 | \$50    |
| ■ Hospital (facility) <u>copayment</u>        | \$1,000 |
| ■ Other <u>coinsurance</u>                    | 0%      |

#### This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
Diagnostic tests (*blood work*)  
Prescription drugs  
Durable medical equipment (*glucose meter*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

#### In this example, Joe would pay:

| <i>Cost Sharing</i> |       |
|---------------------|-------|
| <u>Deductibles</u>  | \$0   |
| <u>Copayments</u>   | \$900 |
| <u>Coinsurance</u>  | \$200 |

#### *What isn't covered*

|                                   |                |
|-----------------------------------|----------------|
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,120</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|                                               |         |
|-----------------------------------------------|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$0     |
| ■ <u>Specialist copayment</u>                 | \$50    |
| ■ Hospital (facility) <u>copayment</u>        | \$1,000 |
| ■ Other <u>coinsurance</u>                    | 0%      |

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

#### In this example, Mia would pay:

| <i>Cost Sharing</i> |       |
|---------------------|-------|
| <u>Deductibles</u>  | \$0   |
| <u>Copayments</u>   | \$700 |
| <u>Coinsurance</u>  | \$50  |

#### *What isn't covered*

|                                   |              |
|-----------------------------------|--------------|
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$750</b> |

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



|                                                                                                                                                                                                                                                                                              |                                                             |                                                                                                                                                                                                                                                                                                                                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Health care coverage is important for everyone.</b>                                                                                                                                                                                                                                       |                                                             |                                                                                                                                                                                                                                                                                                                                        |
| If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984. We provide free communication aids and services for anyone with a disability or who needs language assistance. |                                                             |                                                                                                                                                                                                                                                                                                                                        |
| We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability. If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.          |                                                             |                                                                                                                                                                                                                                                                                                                                        |
| Office of Civil Rights Coordinator<br>300 E. Randolph St., 35 <sup>th</sup> Floor<br>Chicago, IL 60601                                                                                                                                                                                       | Phone:<br>TTY/TDD:<br>Fax:                                  | 855-664-7270 (voicemail)<br>855-661-6965<br>855-661-6960                                                                                                                                                                                                                                                                               |
| You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:                                                                                                                                                                    |                                                             |                                                                                                                                                                                                                                                                                                                                        |
| U.S. Dept. of Health & Human Services<br>200 Independence Avenue SW<br>Room 509F, HHH Building 1019<br>Washington, DC 20201                                                                                                                                                                  | Phone:<br>TTY/TDD:<br>Complaint Portal:<br>Complaint Forms: | 800-368-1019<br>800-537-7697<br><a href="https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf">https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf</a><br><a href="https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html">https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html</a> |

|            | To receive language or communication assistance free of charge, please call us at 855-710-6984.                                     |
|------------|-------------------------------------------------------------------------------------------------------------------------------------|
| Español    | Llámenos al 855-710-6984 para recibir asistencia lingüística o comunicación en otros formatos sin costo.                            |
| العربية    | لتلقي المساعدة اللغوية أو التواصل مجاناً، يرجى الاتصال بنا على الرقم 855-710-6984.                                                  |
| 繁體中文       | 如欲獲得免費語言或溝通協助，請撥打855-710-6984與我們聯絡。                                                                                                 |
| Français   | Pour bénéficier gratuitement d'une assistance linguistique ou d'une aide à la communication, veuillez nous appeler au 855-710-6984. |
| Deutsch    | Um kostenlose Sprach- oder Kommunikationshilfe zu erhalten, rufen Sie uns bitte unter 855-710-6984 an.                              |
| ગુજરાતી    | ભાષા અથવા સંચાર સહાય મફતમાં મેળવવા માટે, કૃપા કરીને અમને 855-710-6984 પર કૉલ કરો.                                                   |
| हिंदी      | निःशुल्क भाषा या संचार सहायता प्राप्त करने के लिए, कृपया हमें 855-710-6984 पर कॉल करें।                                             |
| Italiano   | Per assistenza gratuita alla lingua o alla comunicazione, chiami il numero 855-710-6984.                                            |
| 한국어        | 언어 또는 의사소통 지원을 무료로 받으려면 855-710-6984번으로 전화해 주세요.                                                                                    |
| Navajo     | Niná: Doo bilagáana bizaad dinit's'á'góó, shá ata' hodooni nínízingo, t'áá'jii'k'eh bee náhaz'á. 1-866-560-4042 jį' hodiilni.       |
| فارسی      | برای دریافت کمک زبانی یا ارتباطی رایگان، لطفاً با شماره 855-710-6984 تماس بگیرید.                                                   |
| Polski     | Aby uzyskać bezpłatną pomoc językową lub komunikacyjną, prosimy o kontakt pod numerem 855-710-6984.                                 |
| Русский    | Чтобы бесплатно воспользоваться услугами перевода или получить помощь при общении, звоните нам по телефону 855-710-6984.            |
| Tagalog    | Para makatanggap ng tulong sa wika o komunikasyon nang walang bayad, pakitawagan kami sa 855-710-6984.                              |
| اردو       | مفت میں زبان یا مواصلت کی مدد موصول کرنے کے لیے، براہ کرم ہمیں 855-710-6984 پر کال کریں۔                                            |
| Tiếng Việt | Để được hỗ trợ ngôn ngữ hoặc giao tiếp miễn phí, vui lòng gọi cho chúng tôi theo số 855-710-6984.                                   |