



**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, visit [www.bcbsil.com](http://www.bcbsil.com) or by calling 1-800-458-6024. 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 <https://www.healthcare.gov/sbc-glossary/> or call 1-855-756-4448 to request a copy.

| Important Questions                                                | Answers                                                                                                                                                                                                                                                        | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall deductible?</b>                             | For <u>In-Network</u> :<br>\$1,500 Individual / \$4,500 Family<br>For <u>Out-of-Network</u> :<br>\$3,000 Individual / \$9,000 Family<br>Health Care Account:<br>\$1,000 Individual / \$3,000 Family<br>Self-Pay Corridor:<br>\$500 Individual / \$1,500 Family | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .                                                                                                           |
| <b>Are there services covered before you meet your deductible?</b> | Yes. Certain <u>preventive care</u> , services that charge a <u>copay</u> , emergency room services and <u>prescription drugs</u> are covered before you meet your <u>deductible</u> .                                                                         | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> . |
| <b>Are there other deductibles for specific services?</b>          | No.                                                                                                                                                                                                                                                            | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>What is the out-of-pocket limit for this plan?</b>              | For <u>In-Network</u><br>\$2,650 Individual / \$7,950 Family<br>For <u>Out-of-Network</u><br>\$5,300 Individual / \$15,900 Family<br><u>Prescription drug</u> expense limit:<br>\$1,000 Individual / \$2,000 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.                                                                                                                                                                                                                                 |
| <b>What is not included in the out-of-pocket limit?</b>            | <u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.<br>Certain specialty pharmacy drugs are considered non-essential health benefits and fall outside of the <u>out-of-pocket limits</u> . The                   | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .                                                                                                                                                                                                                                                                                                                                                                                                              |

| Important Questions                                     | Answers                                                                                                                                           | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|---------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                         | cost of these drugs (though reimbursed by the manufacturer at no cost to you) will not be applied towards satisfying your out-of-pocket maximums. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Will you pay less if you use a network provider?</b> | Yes. For a list of <u>In-Network Providers</u> , visit <a href="http://www.bcbsil.com">www.bcbsil.com</a> or call 1-800-458-6024.                 | This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>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. |
| <b>Do you need a referral to see a specialist?</b>      | 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                                                                                                                              |
|---------------------------------------------------------------|--------------------------------------------------|--------------------------------------------------------------|-----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                               |                                                  | <u>In-Network Provider</u><br>(You will pay the least)       | <u>Out-of-Network Provider</u><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 | \$20 <u>copay</u> /visit<br><u>deductible</u> does not apply | 30% <u>coinsurance</u>                                    | Virtual Visits (Telehealth) covered at the <u>In-Network Provider</u> level per visit by a Designated Virtual <u>Network Provider</u> . No Virtual Coverage <u>out-of-network</u> . |
|                                                               | <u>Specialist</u> visit                          | \$30 <u>copay</u> /visit<br><u>deductible</u> does not apply | 30% <u>coinsurance</u>                                    | None                                                                                                                                                                                |
|                                                               | <u>Preventive care/screening/immunization</u>    | No Charge; <u>deductible</u> does not apply                  | No Charge; <u>deductible</u> does not apply               | 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)       | No Charge for first \$300 then 10% <u>coinsurance</u>        | 30% <u>coinsurance</u>                                    | <u>Preauthorization</u> may be required; see your benefit booklet* for details.                                                                                                     |
|                                                               | Imaging (CT/PET scans, MRIs)                     | No Charge for first \$300 then 10% <u>coinsurance</u>        | 30% <u>coinsurance</u>                                    |                                                                                                                                                                                     |

\*For more information about limitations and exceptions, see the plan or policy document at [www.bcbsil.com](http://www.bcbsil.com).

| Common Medical Event                                                                                                                                                                                                               | Services You May Need                          | What You Will Pay                                             |                                                               | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|---------------------------------------------------------------|---------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                    |                                                | In-Network Provider<br>(You will pay the least)               | Out-of-Network Provider<br>(You will pay the most)            |                                                                                                                                                                                                                                                                                                                                       |
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <b>prescription drug coverage</b> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a> or 1-800-711-0917 | Generic drugs                                  | \$10 <u>copay</u> retail / \$20 <u>copay</u> mail order       | \$10 <u>copay</u> retail                                      | Retail 34 day supply.<br>Mail order 90 day supply.<br>RX Out-of-Pocket Expense Limit: \$1,000 Individual/ \$2,000 Family<br>Prior authorization may be required.<br>Please see "Important Questions" regarding the plan's <u>out-of-pocket limit</u> .                                                                                |
|                                                                                                                                                                                                                                    | Preferred brand drugs                          | \$30 <u>copay</u> retail / \$60 <u>copay</u> mail order       | \$30 <u>copay</u> retail                                      |                                                                                                                                                                                                                                                                                                                                       |
|                                                                                                                                                                                                                                    | Non-preferred brand drugs                      | \$50 <u>copay</u> retail / \$100 <u>copay</u> mail order      | \$50 <u>copay</u> retail                                      |                                                                                                                                                                                                                                                                                                                                       |
|                                                                                                                                                                                                                                    | Specialty drugs                                | \$50 <u>copay</u> retail                                      | N/A                                                           |                                                                                                                                                                                                                                                                                                                                       |
| <b>If you have outpatient surgery</b>                                                                                                                                                                                              | Facility fee (e.g., ambulatory surgery center) | 10% <u>coinsurance</u>                                        | 30% <u>coinsurance</u>                                        | <u>Preauthorization</u> may be required.                                                                                                                                                                                                                                                                                              |
|                                                                                                                                                                                                                                    | Physician/surgeon fees                         | 10% <u>coinsurance</u>                                        | 30% <u>coinsurance</u>                                        | None                                                                                                                                                                                                                                                                                                                                  |
| <b>If you need immediate medical attention</b>                                                                                                                                                                                     | <u>Emergency room care</u>                     | \$250 <u>copay</u> /visit<br><u>deductible</u> does not apply | \$250 <u>copay</u> /visit<br><u>deductible</u> does not apply | <u>Copay</u> waived if admitted.                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                                                    | <u>Emergency medical transportation</u>        | 10% <u>coinsurance</u>                                        | 10% <u>coinsurance</u>                                        | <u>Preauthorization</u> may be required for non-emergency transportation; see your benefit booklet* for details.                                                                                                                                                                                                                      |
|                                                                                                                                                                                                                                    | <u>Urgent care</u>                             | \$30 <u>copay</u> /visit<br><u>deductible</u> does not apply  | 30% <u>coinsurance</u>                                        | None                                                                                                                                                                                                                                                                                                                                  |
| <b>If you have a hospital stay</b>                                                                                                                                                                                                 | Facility fee (e.g., hospital room)             | 10% <u>coinsurance</u>                                        | 30% <u>coinsurance</u>                                        | <u>Preauthorization</u> required.                                                                                                                                                                                                                                                                                                     |
|                                                                                                                                                                                                                                    | Physician/surgeon fees                         | 10% <u>coinsurance</u>                                        | 30% <u>coinsurance</u>                                        | None                                                                                                                                                                                                                                                                                                                                  |
| <b>If you need mental health, behavioral health, or substance abuse services</b>                                                                                                                                                   | Outpatient services                            | 10% <u>coinsurance</u>                                        | 30% <u>coinsurance</u>                                        | \$20 PCP <u>copay</u> applies to psychotherapy office visit only. <u>Preauthorization</u> may be required; see your benefit booklet* for details. Virtual Visits (Telehealth) covered at the <u>In-Network Provider</u> level per visit by a Designated Virtual <u>Network Provider</u> . No Virtual Coverage <u>out-of-network</u> . |
|                                                                                                                                                                                                                                    | Inpatient services                             | 10% <u>coinsurance</u>                                        | 30% <u>coinsurance</u>                                        | <u>Preauthorization</u> required.                                                                                                                                                                                                                                                                                                     |

\*For more information about limitations and exceptions, see the plan or policy document at [www.bcbsil.com](http://www.bcbsil.com).

| Common Medical Event                                           | Services You May Need                     | What You Will Pay                                            |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                         |
|----------------------------------------------------------------|-------------------------------------------|--------------------------------------------------------------|----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                           | In-Network Provider<br>(You will pay the least)              | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                |
| If you are pregnant                                            | Office visits                             | \$20 <u>copay</u> /visit<br><u>deductible</u> does not apply | 30% <u>coinsurance</u>                             | <u>Copay</u> applies to first prenatal visit (per pregnancy). <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
|                                                                | Childbirth/delivery professional services | 10% <u>coinsurance</u>                                       | 30% <u>coinsurance</u>                             |                                                                                                                                                                                                                                                                                                                                                |
|                                                                | Childbirth/delivery facility services     | 10% <u>coinsurance</u>                                       | 30% <u>coinsurance</u>                             |                                                                                                                                                                                                                                                                                                                                                |
| If you need help recovering or have other special health needs | <u>Home health care</u>                   | 10% <u>coinsurance</u>                                       | 30% <u>coinsurance</u>                             | Limited to 40 visits per benefit period. <u>Preauthorization</u> may be required.                                                                                                                                                                                                                                                              |
|                                                                | <u>Rehabilitation services</u>            | 10% <u>coinsurance</u>                                       | 30% <u>coinsurance</u>                             | 18 visits per benefit period for Physical Therapy. 18 visits per benefit period for Occupational Therapy. 18 visits per benefit period for Speech Therapy. <u>Preauthorization</u> may be required.                                                                                                                                            |
|                                                                | <u>Habilitation services</u>              | 10% <u>coinsurance</u>                                       | 30% <u>coinsurance</u>                             |                                                                                                                                                                                                                                                                                                                                                |
|                                                                | <u>Skilled nursing care</u>               | 10% <u>coinsurance</u>                                       | 30% <u>coinsurance</u>                             | Limited to 100 days per benefit period. <u>Preauthorization</u> may be required.                                                                                                                                                                                                                                                               |
|                                                                | <u>Durable medical equipment</u>          | 10% <u>coinsurance</u>                                       | 30% <u>coinsurance</u>                             | Benefits are limited to items used to serve a medical purpose. <u>DME</u> benefits are provided for both purchase and rental equipment (up to the purchase price). <u>Preauthorization</u> may be required.                                                                                                                                    |
|                                                                | <u>Hospice services</u>                   | 10% <u>coinsurance</u>                                       | 30% <u>coinsurance</u>                             | <u>Preauthorization</u> may be required.                                                                                                                                                                                                                                                                                                       |
| If your child needs dental or eye care                         | Children's eye exam                       | Not Covered                                                  | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                           |
|                                                                | Children's glasses                        | Not Covered                                                  | Not Covered                                        |                                                                                                                                                                                                                                                                                                                                                |
|                                                                | Children's dental check-up                | Not Covered                                                  | Not Covered                                        |                                                                                                                                                                                                                                                                                                                                                |

#### 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.)**

- Cosmetic surgery
- Long-term care
- Routine foot care (with exception of those diagnosed with diabetes)
- Dental care (Adult and Children)
- Routine eye care (Adult and Children)

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

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (1 per ear every 24 months)
- Infertility treatment (limited to diagnosis only)
- Most coverage provided outside the United States. See [www.bcbsil.com](http://www.bcbsil.com)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (with the exception of inpatient private duty nursing)
- Weight loss programs (except when non-medically supervised)

**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: the [plan](http://www.dol.gov/ebsa/healthreform) at 1-800-458-6024, 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), or 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). 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 on how 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: Blue Cross and Blue Shield of Illinois at 1-800-458-6024 or visit [www.bcbsil.com](http://www.bcbsil.com), or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your [appeal](#). Contact the Illinois Department of Insurance at (877) 527-9431 or visit <http://insurance.illinois.gov>.

**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 1-800-458-6024.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-458-6024.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-458-6024.

Navajo (Dine): Dine'ehgo shika at'ohwol ninisingo, kwijigoo holne' 1-800-458-6024.

*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> | \$1,500 |
| ■ <u>Specialist copayment</u>                 | \$30    |
| ■ <u>Hospital (facility) coinsurance</u>      | 10%     |
| ■ <u>Other coinsurance</u>                    | 10%     |

**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>                | \$1,500        |
| <u>Copayments</u>                 | \$30           |
| <u>Coinsurance</u>                | \$1,000        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$2,590</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> | \$1,500 |
| ■ <u>Specialist copayment</u>                 | \$30    |
| ■ <u>Hospital (facility) coinsurance</u>      | 10%     |
| ■ <u>Other coinsurance</u>                    | 10%     |

**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>                | \$900          |
| <u>Copayments</u>                 | \$700          |
| <u>Coinsurance</u>                | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,620</b> |

### Mia's Simple Fracture (in-network emergency room visit and follow up care)

|                                               |         |
|-----------------------------------------------|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$1,500 |
| ■ <u>Specialist copayment</u>                 | \$30    |
| ■ <u>Hospital (facility) coinsurance</u>      | 10%     |
| ■ <u>Other coinsurance</u>                    | 10%     |

**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>                | \$1,500        |
| <u>Copayments</u>                 | \$300          |
| <u>Coinsurance</u>                | \$20           |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,820</b> |

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



**BlueCross BlueShield** of Illinois

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company

### Health care coverage is important for everyone.

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  
300 E. Randolph St., 35<sup>th</sup> Floor  
Chicago, IL 60601

Phone: 855-664-7270 (voicemail)  
TTY/TDD: 855-661-6965  
Fax: 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  
200 Independence Avenue SW  
Room 509F, HHH Building 1019  
Washington, DC 20201

Phone: 800-368-1019  
TTY/TDD: 800-537-7697  
Complaint Portal: <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>  
Complaint Forms: <https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html>

### 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 مجاًاً، 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    | 855-710-6984 પર કોલ કરીને મુક્તિ મેળવવા માટે અમારો સંપર્ક કરો.                                                                      |
| فارسی      | برای دریافت کمک زبانی یا ارتباطی رایگان، لطفاً با شماره 855-710-6984 تماس بگیرید.                                                   |
| Italiano   | Per assistenza gratuita alla lingua o alla comunicazione, chiami il numero 855-710-6984.                                            |
| □□□        | 언어 또는 의사소통 지원을 무료로 받으려면 855-710-6984번으로 전화해 주세요.                                                                                    |
| Navajo     | Nin1: Doo bilag1ana bizaad dinits'1'g00, sh1 ata' hodooni n7n7zingo, t'11j77k'eh bee n1 haz'1. 1-866-560-4042 j8 hod7lni.           |
| 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.                                   |