Schedule of Benefits – HMO Premier

Group - PY Premier 2000 HMO HDHP Umbrella 0% No Copays (5743-BC5630-49505780-MH104-HH1-SNF1-PY)

Benefit Year: July 1 through June 30

Effective Date: 07/01/2025

SecurityHealth Plan℠
Promises kept, plain and simple.®

Security Health Plan certifies that you and any covered dependents have coverage as described in your Certificate and Schedule of Benefits as of the effective date shown on the letter you received with your identification cards, subject to the terms, conditions, exclusions, limitations and all other provisions of the group policy.

This Schedule of Benefits shows your specific cost-sharing, as well as any additional benefits, limitations or exclusions not shown in your Certificate. It also provides a very general summary of your benefits for certain types of services; **you will need to read it in conjunction with your Certificate for details about your coverage.** Benefits are calculated according to the benefit year shown above. **NOTE: All services must be received from in-network providers, except as otherwise described in the Certificate.**

Your responsibilities	
Deductible This plan is intended to qualify as a high deductible health plan that may be paired with a health savings account; however, you should check with your tax advisor for guidance on your particular situation.	$2,000 per individual $4,000 per family The individual deductible does not apply under a family plan. One or more members of the family must meet the family deductible before benefits will be paid.
Annual out-of-pocket (Deductible, coinsurance and copayments)	$3,000 per individual $6,000 per family Only the family limit above applies to a family plan.
Dependent wrap coverage In addition to the benefits described in the Certificate, dependents living outside of the service area are provided benefits for covered services from out-of-network providers.	Such coverage shall be provided at the in network level of benefits. Usual, Customary and Reasonable (UCR) fees may apply.

Your benefits	
Ambulance services	Subject to deductible
Anesthesia services	Subject to deductible
Breast cancer (BRCA 1 and 2) gene screening *~Requires prior authorization*	Covered at 100% (Limited to 1 test per lifetime, or, if appropriate as determined by attending provider and meets medically necessity criteria)
Care My Way ®	Subject to deductible
Chiropractic services	Subject to deductible

Your benefits	
Dry needling	Subject to deductible (Limited to 20 visits per individual per calendar year)
Durable medical equipment and medical supplies *~Requires prior authorization*	
• **Approved to be dispensed from a supplier**	Subject to deductible
• **Approved to be dispensed from a network pharmacy**	Refer to pharmacy benefit for pharmacy cost-share
Emergency services	
• **Emergency room facility**	Subject to deductible
• **Other emergency services**	Subject to deductible
Habilitative therapy	
• **Occupational therapy** *~Requires prior authorization*	Subject to deductible
• **Physical therapy** *~Requires prior authorization*	Subject to deductible
• **Speech therapy** *~Requires prior authorization*	Subject to deductible
Hearing examinations	Subject to deductible
Home health care *~Requires prior authorization*	Subject to deductible (Limited to 40 visits per individual per calendar year)
Hospice care	Subject to deductible
Hospital services	
• **Inpatient hospital services** (Including semi-private or special care room, operating room, ancillary services and supplies) *~Requires prior authorization*	Subject to deductible
• **Inpatient/residential mental health and substance use disorder services** *~Requires prior authorization*	Subject to deductible
• **Outpatient hospital and surgical services** (not including emergency room)	Subject to deductible
• **Physician hospital services**	Subject to deductible

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Your benefits	
• **Other hospital services**	Subject to deductible
Infusion therapy	
• **Home infusion services** (when medically appropriate and provider available)	Subject to deductible
• **Outpatient services**	Subject to deductible
Maternity services	
• **Hospital services**	Subject to deductible
• **Physician services**	Subject to deductible
Mental health and substance use disorder services	
• **Outpatient care**	Subject to deductible
• **Transitional care**	Subject to deductible
Nutritional counseling	Subject to deductible
Outpatient laboratory services	Subject to deductible
Outpatient radiology services	Subject to deductible
Physician services	
• **Office visits**	Subject to deductible (Preventive exams covered at 100%)
• **Office visits with primary care physician (PCP)**	Subject to deductible (Preventive exams covered at 100%)
• **Office visits with specialist**	Subject to deductible
• **Other physician services in an office**	Subject to deductible (Preventive immunizations covered at 100%)

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Your benefits	
Preventive care services Please visit www.securityhealth.org/preventive or call 1-800-472-2363 for information on service frequency recommendations and a list of preventive screening services. Tests for an existing condition or illness are not preventive care and are subject to your plan's deductible, coinsurance and/or copays.	Scan this code with your smartphone
• **Preventive exams** (comprehensive physical examination) ○ Well-baby care ○ Well-child care ○ Well-adolescent care ○ Well-adult care ○ Interpersonal and domestic violence screening ○ Nutritional screening ○ Screening and counseling for sexually transmitted infections	Covered at 100%
• **Abdominal aortic aneurysm (ultrasound) screening** (age 65 through 75)	Covered at 100% (Limited to 1 visit per lifetime)
• **Breast feeding support and counseling**	Covered at 100%
• **Cervical cancer screenings** (age 21 through 65)	
○ Human papillomavirus DNA screening (HPV)	1 every five years then subject to deductible
○ Pap smear screening	1 every three years then subject to deductible
• **Chlamydia screening**	1 per calendar year then subject to deductible
• **Colorectal cancer screenings**	
○ Colonoscopy screening (age 45 and older)	1 every five years then subject to deductible
○ Colonoscopy screening for personal or family history of polyps or colorectal cancer	1 every two years then subject to deductible
○ Sigmoidoscopy screening (age 45 and older)	1 every five years then subject to deductible
○ Sigmoidoscopy screening for personal or family history of polyps or colorectal cancer	1 every two years then subject to deductible

Your benefits	
○ Other colorectal cancer screenings ~Fecal occult blood testing (age 45 and older)	1 per calendar year then subject to deductible
• **Gynecological examination** (breast exam and pelvic exam)	1 per calendar year then subject to deductible
• **Hearing screening** (under age 22)	1 per calendar year then subject to deductible
• **Immunizations and vaccinations** (including those needed for travel)	Covered at 100%
• **Laboratory screening services** For a complete list of screening laboratory services and frequency recommendations please refer to Security Health Plan's Preventive Service Guidelines at www.securityhealth.org/preventive or contact us at 1-800-472-2363.	
○ Cholesterol screening (age 40 through 75)	1 per calendar year then subject to deductible
○ Diabetes Type 2 screening (age 35 through 70 with BMI 25+)	1 per calendar year then subject to deductible
○ Hemoglobin (A1C) (diabetics)	2 per calendar year then subject to deductible
○ Lead screening (age 1 through 6)	1 per calendar year then subject to deductible
• **Mammogram to screen for breast cancer** (includes 2D and 3D imaging)	1 per calendar year then subject to deductible
• **Osteoporosis screening (bone density)** ○ Routine osteoporosis screening (age 65 and older) ○ Osteoporosis screening for personal or family history or at increased risk (under age 65)	1 every two years then subject to deductible
• **Prostate cancer screenings**	
○ Digital examination	Subject to deductible
○ Prostate specific antigen test (PSA) (age 55 through 69)	1 per calendar year then subject to deductible

Your benefits	
• **Vision screenings**	
○ Pediatric/adolescent vision screening (until end of the month member turns 19)	Subject to deductible
○ Vision impairment screening (age 1 through 5)	1 per calendar year then subject to deductible
Rehabilitative therapy	
• **Occupational therapy** *~Requires prior authorization*	Subject to deductible
• **Physical therapy** *~Requires prior authorization*	Subject to deductible
• **Speech therapy** *~Requires prior authorization*	Subject to deductible
Skilled nursing facility *~Requires prior authorization*	Subject to deductible (Limited to 30 days per individual per confinement)
Surgical services	Subject to deductible
Temporomandibular joint disorders or TMJ non-surgical treatment *~Requires prior authorization*	Subject to deductible (Limited to 4 physical/occupational visits for diagnosis of TMJ per year)
Transplant services *~Requires prior authorization*	Subject to deductible
Urgent care services	
• **Urgent care office visits**	Subject to deductible
• **Other urgent care services**	Subject to deductible
Vision examinations (age 19 and older)	Subject to deductible

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Pharmacy	
• 100% coverage for preventive prescription drugs (not subject to deductible). Please refer to the Preventive Medication List for a list of covered products. • Up to 30 days worth of prescription drugs constitutes a 1-month supply. For most maintenance prescription drugs you may receive up to a 90-day supply and if applicable, 3 copayments and/or coinsurance and/or deductible will be assessed. • Pharmacy mail service may supply maintenance prescription drugs in a 90-day supply and if applicable, 2 copayments and/or coinsurance and/or deductible will be assessed. • 100% coverage for smoking cessation products, limited to 180 days per year. • The use of a specialty pharmacy may be required for select prescription drugs, as indicated in the Formulary Guide. • Prescription drugs may require prior authorization. • Please refer to our website at www.securityhealth.org/prescription-tools for the most up-to-date prescription drug lists. • Eligible subscribers will receive a quarterly over-the-counter (OTC) credit. ○ Please refer to www.securityhealth.org/OTC or call 1-877-216-8533 for benefit information and list of products.	Subject to deductible. After deductible, the following copayments and/or coinsurance apply to covered prescription drugs until the maximum out-of-pocket is met. $10 copayment per tier 1 prescription or refill. $30 copayment per tier 2 prescription or refill. $60 copayment per tier 3 prescription or refill. 25% coinsurance per tier 4 prescription or refill (specialty prescription drugs). Deductible, copayments and coinsurance may apply to the max out of pocket amounts. If the member receives the brand name prescription drug where a generic is available, the member must pay the applicable copayment/coinsurance plus the ancillary charge. The ancillary charge is the cost difference between the brand name prescription drug and the generic prescription drug. The ancillary charge will not count towards the prescription out-of-pocket limit.

Dependent coverage
Dependent children are covered from birth through the end of the month they attain the age of 26. In addition, a child who meets the criteria above and is a full-time student as defined in this policy has an extension past age 26, if the child was called to federal active duty in the National Guard or in reserve component of the U.S. Armed Forces while the child was under age 27 and attending, on a full-time basis, an institution of higher learning. Such extension ends on the date described in the full-time student definition in the policy and any previous amendments.

Prior authorization

Note: It is your responsibility to ensure that the prior authorization is obtained and completed by your provider.

Your provider should start the prior authorization process by visiting www.securityhealth.org/providers or contact our Provider Assistance Line at 1-800-548-1224.

You can also call our Customer Service Department at 1-800-472-2363 to find out what medical services require prior authorization.

For a complete list of medical and pharmacy services requiring prior authorizations visit www.securityhealth.org/authorization or scan the QR code with your smartphone.

Scan this code with your smartphone

Notice of Nondiscrimination

Security Health Plan of Wisconsin, Inc., complies with applicable federal civil rights laws and does not discriminate, exclude or treat people differently on the basis of race, color, national origin, religion, pregnancy and related conditions, sex, (including sexual orientation, gender identity, sex stereotypes, sex characteristics and intersex traits), age, disability, health status, marital status, arrest or conviction record or military participation in the administration of the plan, including enrollment and benefit determinations.

Limited English Proficiency Language Services

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-800-472-2363 (TTY 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-472-2363 (TTY 711).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-472-2363 (TTY 711).

If you require materials in large print, please call 1-800-472-2363 (TTY 711).

SecurityHealth Plan PY Premier 2000 HMO HDHP Umbrella 0% No Copays (5743-BC5630-49505780-MH104-HH1-SNF1-PY)

Coverage for: Individual/Family | **Plan Type:** HMO Premier

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, refer to www.securityhealth.org/certificates or call 1-800-472-2363. 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 1-800-472-2363 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$2,000 individual / $4,000 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out–of–pocket limit for this plan?	$3,000 individual / $6,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out–of–pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.securityhealth.org/directory or call 1-800-472-2363 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance-billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

- 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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	Not covered	None
	Specialist visit	0% coinsurance	Not covered	Please refer to your policy plan documents for more specific information.
	Preventive care/screening /immunization	Covered at 100%	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	Not covered	Please refer to your policy plan documents for more specific information.
	Imaging (CT/PET scans, MRIs)	0% coinsurance	Not covered	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.securityhealth.org/prescription-tools	Generic drugs (Tier 1)	Subject to deductible, then $10 copayment	Not covered	Provider means pharmacy for purposes of this section. Most pharmacies nationwide are included in the provider network (more than 50,000 pharmacies). You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have prior authorization requirements. You may be required to use a lower-cost drug(s) prior to coverage being available for certain prescribed drugs.
	Preferred brand drugs (Tier 2)	Subject to deductible, then $30 copayment	Not covered	
	Non-preferred brand drugs (Tier3)	Subject to deductible, then $60 copayment	Not covered	
	Specialty drugs (Tier 4)	Subject to deductible, then 25% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	Not covered	None
	Physician/surgeon fees	0% coinsurance	Not covered	

*For more information about limitations and exceptions, see the plan or policy document at www.securityhealth.org

Common Medical Event	Services You May Need	What You Will Pay		Limitations & Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	Cost sharing may apply for services performed in the ER (such as labs, X-rays).
	Emergency medical transportation	0% coinsurance	0% coinsurance	None
	Urgent care	0% coinsurance	0% coinsurance	When you're in the service area, benefits are payable for urgent care services only when provided by an affiliated provider. Cost sharing may apply for services performed in the UC (such as labs, X-rays).
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	Not covered	None
	Physician/surgeon fee	0% coinsurance	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	Not covered	Please refer to your policy plan documents for more specific information.
	Inpatient services	0% coinsurance	Not covered	
If you are pregnant	Office visits	0% coinsurance	Not covered	None
	Childbirth/delivery professional services	0% coinsurance	Not covered	Depending on the type of services cost sharing may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	0% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	Not covered	Limited to 40 visits per individual per calendar year.
	Rehabilitation services	0% coinsurance	Not covered	None
	Habilitation services	0% coinsurance	Not covered	None
	Skilled nursing care	0% coinsurance	Not covered	Limited to 30 days per individual per confinement.
	Durable medical equipment	0% coinsurance	Not covered	Please refer to your policy plan documents for more specific information.
	Hospice services	0% coinsurance	Not covered	None

*For more information about limitations and exceptions, see the plan or policy document at www.securityhealth.org

Common Medical Event	Services You May Need	What You Will Pay		Limitations & Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	0% coinsurance	Not covered	Please refer to your policy plan documents for more specific information.
	Children's glasses	Not covered	Not covered	Glasses are generally not covered; please refer to your plan documents for specifics.
	Children's dental check-up	Not covered	Not covered	This policy does not include pediatric dental services as required under the federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a standalone product. Please contact your insurance carrier or the Federally Facilitated Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

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.)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture (if prescribed by a physician for rehabilitation purposes)
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Chiropractic care
- Hearing aids
- Routine eye care (Adult)

*For more information about limitations and exceptions, see the plan or policy document at www.securityhealth.org

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 your state insurance department, of the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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 or call 1-800-318-2596.

Your Grievance and Appeal 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 Security Health Plan at 1-715-221-9258 or 1-800-472-2363. You may also contact the Office of the Commission of Insurance (OCI) at (608) 266-3585 or (800) 236-8517.

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 coverages. 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 Standard? 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

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

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 plan's overall deductible	$2,000
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	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)

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$2,000
Copayments	$50
Coinsurance	$0
What isn't covered	
Limits or Exclusions	$0
The total Peg would pay is	**$2,050**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2,000
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	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)

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$2,000
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or Exclusions	$0
The total Joe would pay is	**$2,700**

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

The plan's overall deductible	$2,000
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	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)

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or Exclusions	$0
The total Mia would pay is	**$2,000**

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

Addendum

Notice of Nondiscrimination:

Discrimination is against the law
Security Health Plan of Wisconsin, Inc., complies with applicable federal civil rights laws and does not discriminate, exclude or treat people differently on the basis of race, color, national origin, religion, pregnancy and related conditions, sex (including sexual orientation, gender identity, sex stereotypes, sex characteristics and intersex traits), age, disability, health status, marital status, arrest or conviction record or military participation in the administration of the plan, including enrollment and benefit determinations.

Security Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Service at 1-800-472-2363 (TTY: 711). If you believe that Security Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, health status, marital status, arrest or conviction or military participation, you can file a grievance with:

Security Health Plan
Attn: Grievances
1515 North Saint Joseph Avenue
Marshfield, WI 54449-8000

Phone: 715-221-9596 (TTY: 711) Fax: 715-221-9424
Email: shp.appeals.grievance@securityhealth.org

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Security Health Plan can help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201

Phone: 1–800–368–1019 or 800–537–7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Access Services:

English:
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-472-2363 (TTY: 711).

Spanish:
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-472-2363 (TTY: 711).

Hmong:
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-472-2363 (TTY: 711).

Chinese:
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-472-2363 (TTY: 711).

German:
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-472-2363 (TTY: 711).

Russian:
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-472-2363 (телетайп: 711).

Vietnamese:
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-472-2363 (TTY: 711).

Pennsylvania Dutch:
Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-472-2363 (TTY: 711).

French:
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-472-2363 (ATS : 711).

Polish:
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-472-2363 (TTY: 711).

Hindi:
ध्यान द: यद आप हदी बोलते ह तो आपके लिए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-800-472-2363 (TTY: 711) पर कॉल कर।

Albanian:
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-472-2363 (TTY: 711).

Tagalog:
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-472-2363 (TTY: 711).

العربية (Arabic)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-274-2363 (رقم هاتف الصم والبكم 117).

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-800-472-2363 (TTY 711) 번으로 전화해 주십시오.

ພາສາລາວ (Lao)
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-472-2363 (TTY 711).

မြန်မာ (Burmese)
သတိပြုရန်- သင်အင်္ဂလိပ်စကားပြောဆိုပါက၊ ဘာသာစကားအကူအညီပေးရေးဝန်ဆောင်မှုများသည် သင့်အား အခမဲ့ရရှိနိုင်ပါသည်။
1-800-472-2363 (TTY 711) ကိုခေါ်ဆိုပါ။.

Soomaali (Somali)
ATENSYON: Haddii aad ku hadasho afka Soomaaliha, adeegyada caawimada luqadda waxaa laguu heli karaa iyagoo bilaash ah. Wac 1-800-472-2363 (TTY 711).

If you require materials in large print, please call 1-800-472-2363 (TTY: 711).