CIS Copay Plan E
Alternative Care
Benefits Summary
Effective January 1, 2025

cis benefits
www.cisbenefits.org

These medical plans are insured by CIS but administered by Regence BlueCross BlueShield (BCBS) of Oregon. This means that CIS, not Regence BCBS, pays for your covered medical services and supplies.

Copay Plan E	
Deductible Per Calendar Year	$250 Individual $750 Family
Out-of-Pocket Maximum Per Calendar Year **Category 1 & 2** - Preferred and Participating Provider (includes deductible and medical copays but does not include prescription copays)	$2,250 Individual $4,750 Family
Category 3 - Non-Preferred Provider (includes deductible and medical copays but does not include prescription copays)	$4,250 Individual $8,750 Family

Medical Services	**Member Pays** **Category 1 - Preferred**	**Member Pays** **Category 2 - Participating** **Category 3 - Non-Preferred**
Preventive Care Services		
Routine well-baby care, physical examinations, health screenings, and immunizations *(for a list of covered services, visit our website regence.com, hover over "Member dashboard" at the top, select Preventive Care from the drop down)*	0% for Category 1 & 2 (*deductible waived*) 40% for Category 3 (*after deductible*)	
Professional Services	**After Deductible – Member Pays**	
Office visits for illness or injury, mental/behavioral health or substance use disorder *(primary care, specialist, naturopath, urgent/immediate care center or virtual care)*	$5 copay for first 3 visits for Primary Care, Behavioral Health and Virtual Care visits $20 copay for additional office visits *(deductible waived)*	40%
Outpatient laboratory, radiology, and diagnostic procedures	$0 up to first $400 *(deductible waived)* then 20%	40%
Maternity care	20%	40%
Therapeutic injections including allergy shots	20%	40%
Hospital/Facility Services	**After Deductible - Member Pays**	
Ambulatory Surgical Center	10% *(20% for all other facilities)*	40%
Emergency room care *(including professional charges)*	20% after $100 copay *(copay waived if admitted)*	
Inpatient/outpatient surgery and surgeon fees	20%	40%
Inpatient mental/behavioral health & substance use disorder	20%	20% - Category 2 40%- Category 3
Skilled Nursing Facility – *120 inpatient days per year*	20%	40%
Other Services	**After Deductible - Member Pays**	
Ambulance	20%	
Rehabilitation Services*: Inpatient: Unlimited / Outpatient: 77 visits per year (visit limit shared with Neurodevelopmental therapy)*	20%	40%
Hearing Aids - *applies to children 18 years or younger or children 19 to 25 enrolled in an accredited education institution*	20% *(deductible waived)*	40% *(deductible waived)*
Home health care - *180 visits per year*	20%	40%
Hospice – *14 respite days per lifetime*	0% *(deductible waived)*	40%
Durable Medical Equipment	20%	40%
Weight Management/Nutritional Counseling and Bariatric Surgery: - Weight management and nutritional counseling visits *Four visits per year*	0% *(deductible waived)*	40%

- Bariatric surgery may be covered to treat morbid obesity (participant must meet participation requirements) *Limited to one surgery per claimant lifetime*	\$1,000 copay then 20% *(does not accumulate towards the out-of-pocket maximum)*	\$1,000 copay then 40% (*does not accumulate towards the out-of-pocket maximum)*

Prescription Medication Benefit *If you need drugs to treat your illness or condition, your prescription drug coverage is administered through Express Scripts (ES). Please visit Express Scripts' web site at www.express-scripts.com or contact their customer service at 1 (800) 496-4182.* *Regence BlueCross BlueShield of Oregon assumes no liability for the accuracy of your prescription drug benefits information.*	**At the Pharmacy (30-day supply)** **Member Pays**	**Mail Order thru the Express Scripts Pharmacy Program (90-day supply)** **Member Pays**
Individual deductible per calendar year	No deductible	
Out-of-pocket maximum each calendar year	\$2,500 per person/\$7,500 per family	
Generic drugs	\$10 copay	\$20 copay
Preferred brand drugs	\$40 copay	\$80 copay
Non-Preferred brand drugs	\$100 copay	\$200 copay
	Accredo Specialty Pharmacy (30-day supply)	
Specialty Generic	\$50 copay	N/A
Specialty Preferred brand drugs	\$100 copay	N/A
Specialty Non-Preferred brand drugs	\$200 copay	N/A
Limitations and Exceptions	***Out-of-pocket limit*** \$2,500 */ claimant / year. Coverage is limited to 30-day supply retail or 90-day supply mail order. Long-term medication fills at participating retail pharmacies may be filled for up to a 90-day supply and will follow the mail order copayment structure. Visit Express Scripts' website for details. Specialty drug coverage is limited to a 30-day supply and must be filled through Accredo Specialty Pharmacy.* *Specialty medications filled at a retail pharmacy are subject to 100% copayment/coinsurance, and this amount does not accumulate towards the out-of-pocket maximum.* *Certain preventive items and services as defined by the Affordable Care Act are covered at zero-dollar cost share. Product Selection Cost – If you request and obtain a brand name drug when a generic equivalent is available, you are responsible for the applicable copayment plus the cost difference between the brand name drug and the generic drug.*	

Additional Medical Services

Alternative Care Services	
Acupuncture and Chiropractic Spinal Manipulations	No deductible, any provider - $20 Copay – Maximum allowance of 12 visits per calendar year for Acupuncture and 20 visits per calendar year for Chiropractic Spinal Manipulations.

Other services included in your CIS medical plan	Contact Information
Hinge Health - Hinge Health provides all the tools you need to get moving again from the comfort of your home. You'll get exercise therapy tailored to your condition and a personal care team of experts. Best of all, there's no additional cost to you.	To learn more, please call 1 (855) 902-2777 or sign on to the CIS Health Manager at www.regence.com. Scroll down to Resources and click on Hinge Health.
Lantern (formerly SurgeryPlus) – A comprehensive surgical program that provides a personalized concierge experience from dedicated Care Advocates and access to quality-centric health care through a network of credentialed surgeons. By using the SurgeryPlus benefit, you may also save money through reduced financial responsibility.	To learn more, please call (833) 633-0511, go to cisbenefit.surgeryplus.com, or email cisbenefits@surgeryplus.com
MDLIVE (Telehealth) - With MDLIVE's telehealth service, you can see a doctor or therapist from home, work or on the go, 24/7/365. Board-certified doctors visit with you by phone or secure video to treat non-emergency medical conditions. They can diagnose symptoms, prescribe medication, and send prescriptions to your pharmacy.	To learn more, please call 1 (888) 725-3097 or sign on to the CIS Health Manager at www.regence.com. Scroll down to Resources and click on MDLIVE
Chronic Condition Coaching supports and educates members with chronic conditions including hypertension, diabetes, COPD, CAD, CHF, asthma and obesity.	To learn more, please call 1 (866) 865-6725.
BeyondWell - A comprehensive well-being solution for members that integrates wellness activities, goals, rewards and challenges into a single location for a holistic wellness offering.	To learn more, please call 1 (866) 865-6725 or sign on to the CIS Health Manager at www.regence.com. Scroll down to Resources and click on BeyondWell
Case Management - Supports and educates members with serious illnesses or injuries.	To learn more, please call 1 (866) 543-5765 or sign on to the CIS Health Manager at www.regence.com. Scroll down to Resources and click on Care Management
Pregnancy Program (*Childbirth to Newborn resources*).	To learn more, please call 1 (888) 569-2229 or sign on to the CIS Health Manager at www.regence.com. Scroll down to Resources and click on Pregnancy Program.
BlueCard Program (Out of Area Services) – access hospital and physicians when outside the four-state area Regence services (Oregon, Idaho, Utah and Washington) as well as receive care in 200 countries around the world.	Find a provider near you at www.regence.com or call 1 (800) 810-BLUE (2583).

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, go to https://regence.com or call 1 (888) 370-6159. 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 healthcare.gov/sbc-glossary or call 1 (888) 370-6159 to request a copy. **Please Note:** Your medical plan is provided and insured by CIS, but administered by Regence BlueCross BlueShield of Oregon. This means that CIS, not Regence BlueCross BlueShield of Oregon, pays for your covered medical services and supplies.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$250 individual / $750 family per calendar year.	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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Certain preventive care and those services listed below as "deductible does not apply." "No charge" means $0 copayment or 0% coinsurance, regardless of deductible applicability	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 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?	Preferred provider & participating provider: $2,250 individual / $4,750 family per calendar year. Non-participating provider: $4,250 individual / $8,750 family per calendar year.	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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, prescription drug out-of-pocket limit, 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 https://regence.com/go/OR/Preferred or call 1 (888) 370-6159 for a list of network providers.	You pay the least if you use a provider in the preferred network. You pay more if you use a provider in the participating network. You will pay the most if you use a non-participating 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 a non-participating 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
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Non-participating Provider (You pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$5 copay / upfront office visit, deductible does not apply; $20 copay / additional office visit (after upfront limit), deductible does not apply; 20% coinsurance for other services	40% coinsurance	40% coinsurance	First 3 upfront office visits / year. Limit is for primary care and behavioral health visits combined.
	Specialist visit	$20 copay / office visit, deductible does not apply; 20% coinsurance for other services	40% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	No charge, deductible does not apply	No charge, deductible does not apply	40% coinsurance	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)	No charge, deductible does not apply for the first $400 / year, then 20% coinsurance for outpatient services;	40% coinsurance	40% coinsurance	Once outpatient diagnostic tests and imaging combined reach $400 / year, services are covered at the coinsurance specified for preferred providers only. All other services are covered at the coinsurance specified, after deductible.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Non-participating Provider (You pay the most)	
		20% coinsurance for inpatient services			
	Imaging (CT/PET scans, MRIs)	No charge, deductible does not apply for the first $400 / year, then 20% coinsurance for outpatient services; 20% coinsurance for inpatient services	40% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition	Specialty generic drugs & generic drugs	Not applicable, refer to the participating provider column.	$50 copay 30-day / specialty generic prescription through Accredo Specialty Pharmacy; $10 copay 30-day / retail prescription; $20 copay 90-day / mail order prescription	Not covered	Out-of-pocket limit: $2,500 claimant / $7,500 family / year. 30-day supply / retail prescription 90-day supply / mail order prescription Long term medication fills at participating retail pharmacies may be filled for up to a 90-day supply and will follow the mail order copayment structure. Visit Express Scripts website for details. 30-day supply / specialty drug prescription Specialty drug coverage is limited to a 30-day supply and must be filled through Accredo Specialty Pharmacy. Specialty drugs filled at a retail pharmacy are subject to 100% copayment / coinsurance, and this amount does not accumulate towards the out-of-pocket limit. Certain preventive items and services as defined by the Affordable Care Act are covered at zero-dollar cost share.
	Preferred brand drugs	Not applicable, refer to the participating provider column.	$40 copay 30-day / retail prescription; $80 copay 90-day / mail order prescription	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Non-participating Provider (You pay the most)	
Your prescription drug coverage is administered through Express Scripts (ES). Please visit Express Scripts' web site at www.express-scripts.com or contact their customer service at 1 (800) 496-4182. Regence BlueCross BlueShield of Oregon assumes no liability for the accuracy of your prescription drug benefits information.	Non-Preferred Brand drugs	Not applicable, refer to the participating provider column.	$100 copay 30-day / retail prescription; $200 copay 90-day / mail order prescription	Not covered	No charge, deductible does not apply for certain preventive drugs, contraceptives and immunizations at a participating pharmacy. Production Selection Cost – If you request and obtain a brand name drug when a generic equivalent is available, you will be charged a penalty equal to the cost difference between the brand name drug and the generic drug.
	Preferred specialty drugs & specialty drugs	Not applicable, refer to the participating provider column.	$100 copay 30-day / preferred specialty prescription; $200 copay 30-day / specialty prescription; Specialty drugs must be filled through Accredo Specialty Pharmacy.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance for ambulatory surgery centers; 20% coinsurance for all other facilities	40% coinsurance	40% coinsurance	None
	Physician/surgeon fees	10% coinsurance for ambulatory surgery center physicians; 20% coinsurance for all other physicians	40% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Non-participating Provider (You pay the most)	
If you need immediate medical attention	Emergency room care	20% coinsurance after $100 copay / visit	20% coinsurance after $100 copay / visit	20% coinsurance after $100 copay / visit	Copayment applies to facility charge for each visit (waived if admitted), whether or not the deductible has been met.
	Emergency medical transportation	20% coinsurance	20% coinsurance	20% coinsurance	None
	Urgent care	$20 copay / visit, deductible does not apply; 20% coinsurance for other services	40% coinsurance	40% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$5 copay / upfront office or psychotherapy visit, deductible does not apply; $20 copay / additional office or psychotherapy visit (after upfront limit), deductible does not apply; No charge, deductible does not apply for other services	$20 copay / office or psychotherapy visit, deductible does not apply; No charge, deductible does not apply for other services	40% coinsurance	First 3 upfront visits / year. Limit is for primary care and behavioral health visits combined.
	Inpatient services	20% coinsurance	20% coinsurance	40% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Non-participating Provider (You pay the most)	
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	40% coinsurance	180 visits / year
	Rehabilitation services	20% coinsurance	40% coinsurance	40% coinsurance	77 outpatient visits / year for all habilitation and outpatient rehabilitation services Includes physical therapy, occupational therapy, speech therapy and neurodevelopmental therapy services.
	Habilitation services	20% coinsurance	40% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	40% coinsurance	120 inpatient days / year
	Durable medical equipment	20% coinsurance	40% coinsurance	40% coinsurance	None
	Hospice services	No charge, deductible does not apply	No charge, deductible does not apply	40% coinsurance	14 respite inpatient or outpatient days / lifetime
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	
	Children's dental check-up	Not covered	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, except congenital anomalies
- Dental care
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care
- Routine foot care, except for diabetic patients
- Weight loss programs

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

- Abortion
- Acupuncture, 12 visits / year
- Bariatric surgery, 1 surgery / lifetime
- Chiropractic care, 20 visits / year
- Hearing aids (individuals up to age 26), 1 per ear / year
- Non-emergency care when traveling outside the U.S.

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 U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1 (877) 267-2323 ext. 61565 or cciio.cms.gov or your state insurance department. You may also contact the plan at 1 (888) 370-6159. 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 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 the plan at 1 (888) 370-6159 or visit regence.com or the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or dol.gov/ebsa/healthreform. You may also contact the Oregon Division of Financial Regulation by calling 1 (503) 947-7984 or the toll-free message line at 1 (888) 877-4894; by writing to the Oregon Division of Financial Regulation, Consumer Advocacy Unit, P.O. Box 14480, Salem, OR 97309-0405; through the Internet at: dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx; or by E-mail at: DFRInsuranceHelp@oregon.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 (888) 370-6159.

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 plan's overall deductible	**$250**
Specialist copayment	**$20**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	$250
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,310**

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

The plan's overall deductible	**$250**
Specialist copayment	**$20**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	$250
Copayments	$800
Coinsurance	$100
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	**$1,350**

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

The plan's overall deductible	**$250**
Specialist copayment	**$20**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	$250
Copayments	$200
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$850**

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

NONDISCRIMINATION NOTICE

Regence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Regence does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Regence:
Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services 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 assistance services to people whose primary language is not English, which may include:

- Qualified interpreters
- Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Civil Rights Coordinator.

If you believe that Regence has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

Customer Service
Civil Rights Coordinator
PO Box 1106
Lewiston, ID 83501-1106
Phone: 1-888-344-6347, (TTY: 711)
Fax: 1-888-309-8784
Email: CS@regence.com

Medicare Customer Service
Phone: 1-800-541-8981 (TTY: 711)
Email: medicareappeals@regence.com

VSP Customer Service
Phone: 1-844-299-3041
TTY: 1-800-428-4833

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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-344-6347 (TTY: 711).

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 1-888-344-6347 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-344-6347 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-344-6347 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-344-6347 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-344-6347 (телетайп: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-344-6347 (ATS : 711)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-344-6347 (TTY:711）まで、お電話にてご連絡ください。

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíilnih 1-888-344-6347 (TTY: 711.)

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea te ke lava 'o ma'u ia. ha'o telefonimai mai ki he fika 1-888-344-6347 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-344-6347 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-344-6347 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-344-6347 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-888-344-6347 (TTY: 711)

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፤ በሚከተለው ቁጥር ይደውሉ 1-888-344-6347 (መስማት ለተሳናቸው:- 711)።

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-344-6347 (телетайп: 711)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-344-6347 (टिटिवाइ: 711

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-344-6347 (TTY: 711)

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-344-6347 (TTY: 711)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-344-6347 (TTY: 711)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-344-6347 (TTY: 711)

Afaan dubbattan Oroomiffaa tiif, tajaajila gargaarsa afaanii tola ni jira. 1-888-344-6347 (TTY: 711) tiin bilbilaa.

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-344-6347 (TTY: 711) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم TTY: 711)