Your summary of benefits

Anthem

Anthem® Blue Cross

Your 2026 Contract Code: 94HX

Your Plan: Anthem Platinum PPO 15/40/10%

Your Network: Prudent Buyer PPO

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. Unless stated otherwise, the limitations for In- and Out-of-Network services are combined and services received in an office, Ambulatory Surgical Center, or outpatient facility are combined across all outpatient settings. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge
Mental Health & Substance Use Disorder Services	No charge
Specialist care	$40 copay per visit

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	$0 person / $0 family	$2,000 person / $4,000 family
Overall Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period.*	$3,800 person / $7,600 family	$7,600 person / $15,200 family
The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per member deductible and per member out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per member deductible or per member out-of-pocket limit. *In-Network and Out-of-Network out-of-pocket limit amounts are separate and do not accumulate toward each other.* *Your copays, coinsurance and deductible count toward your out-of-pocket limit. However, member cost sharing for the following service(s) do not apply toward the out-of-pocket limit: adult vision.*		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*		
Primary Care (PCP) and Mental Health and Substance Use Disorder Services *virtual and office*	$15 copay per visit	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Specialist Provider *virtual and office*	$40 copay per visit	50% coinsurance after medical deductible is met
Other Practitioner Visits		
Maternity Doctor services		
Prenatal care	No charge	50% coinsurance after medical deductible is met
Delivery	10% coinsurance	50% coinsurance after medical deductible is met
Postpartum care	$15 copay per visit	50% coinsurance after medical deductible is met
Retail Health Clinic Visit	$15 copay per visit	50% coinsurance after medical deductible is met
Chiropractic/Manipulation Therapy *Coverage is limited to 20 visits per year.*	$15 copay per visit	Not covered
Acupuncture	$15 copay per visit	Not covered
Other Services in an Office		
Allergy Testing	10% coinsurance	50% coinsurance after medical deductible is met
Prescription Drugs - Dispensed in the office *For the drugs itself dispensed in the office through infusion/injection. Maximum of $250 member cost share per drug.*	10% coinsurance	50% coinsurance after medical deductible is met
Surgery	10% coinsurance	50% coinsurance after medical deductible is met
Preventive care / screenings / immunizations	No charge	50% coinsurance after medical deductible is met
Preventive care for Chronic Conditions *per IRS guidelines*	No charge	Cost share is based on the setting services are received.
Diagnostic Services Lab		
Office *Office Cost Share applies only when Freestanding/Reference Labs are not used.*	$10 copay per day	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Freestanding Lab/Reference Lab	No charge	50% coinsurance after medical deductible is met
Outpatient Hospital *Anthem's maximum payment is up to $380 per service for Out-of-Network Providers.*	10% coinsurance	50% coinsurance after medical deductible is met
Diagnostic Services X-Ray		
Office	$10 copay per day	50% coinsurance after medical deductible is met
Freestanding Radiology Center	10% coinsurance	50% coinsurance after medical deductible is met
Outpatient Hospital *Anthem's maximum payment is up to $380 per service for Out-of-Network Providers.*	10% coinsurance	50% coinsurance after medical deductible is met
Diagnostic Services Advanced Diagnostic Imaging - for example: MRI, PET and CAT scans		
Office *Anthem's maximum payment is up to $800 per service for Out-of-Network Providers.*	10% coinsurance	50% coinsurance after medical deductible is met
Freestanding Radiology Center *Anthem's maximum payment is up to $380 per admission for Out-of-Network providers.*	10% coinsurance	50% coinsurance after medical deductible is met
Outpatient Hospital *Anthem's maximum payment is up to $380 per admission for Out-of-Network providers.*	$100 copay per day and 10% coinsurance	50% coinsurance after medical deductible is met
Emergency and Urgent Care		
Urgent Care (Office Setting)	$15 copay per visit	50% coinsurance after medical deductible is met
Emergency Room Facility Services *Your copay will be waived if admitted.*	$200 copay per visit and 10% coinsurance	Covered as In-Network
Emergency Room Doctor and Other Services	10% coinsurance	Covered as In-Network
Ambulance Transportation	10% coinsurance	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	10% coinsurance	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Doctor Services	10% coinsurance	50% coinsurance after medical deductible is met
<u>Outpatient Surgery</u> **Facility Fees**		
Hospital *Anthem's maximum payment is up to $380 per service for Out-of-Network Providers.*	$200 copay per visit and 10% coinsurance	50% coinsurance after medical deductible is met
Ambulatory Surgical Center	$50 copay per visit and 10% coinsurance	50% coinsurance after medical deductible is met
Physician and other services including surgeon fees		
Hospital	10% coinsurance	50% coinsurance after medical deductible is met
Ambulatory Surgical Center	10% coinsurance	50% coinsurance after medical deductible is met
<u>Hospital Stay (all Inpatient stays including Maternity, Mental Health and Substance Use Disorder Services)</u>		
Facility fees (for example, room & board) *Coverage for Skilled Nursing and Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is limited to 100 days combined per benefit period. Anthem's maximum payment is up to $650 per day for Out-of-Network providers.*	10% coinsurance	50% coinsurance after medical deductible is met
Physician and other services including surgeon fees	10% coinsurance	50% coinsurance after medical deductible is met
<u>Home Health Care</u> *Home health visits are limited to 100 visits per benefit period. Benefit limit does not apply to physical, occupational or speech therapy when performed as part of Home Health. Limits are combined for home health care and private duty nursing. Anthem's maximum payment is up to $75 per visit for Out-of-Network.*	10% coinsurance	50% coinsurance after medical deductible is met
<u>Therapy Services</u> **Rehabilitation services (for example, physical/speech/occupational therapy)**		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Office	$15 copay per visit	50% coinsurance after medical deductible is met
Outpatient Hospital *Anthem's maximum payment is up to $380 per admission for Out-of-Network providers.*	10% coinsurance	50% coinsurance after medical deductible is met
Habilitation services (for example, physical/speech/occupational therapy)		
Office	$15 copay per visit	50% coinsurance after medical deductible is met
Outpatient Hospital *Anthem's maximum payment is up to $380 per admission for Out-of-Network providers.*	10% coinsurance	50% coinsurance after medical deductible is met
Pulmonary rehabilitation		
Office	$15 copay per visit	50% coinsurance after medical deductible is met
Outpatient Hospital *Anthem's maximum payment is up to $380 per admission for Out-of-Network providers.*	10% coinsurance	50% coinsurance after medical deductible is met
Cardiac rehabilitation		
Office	$15 copay per visit	50% coinsurance after medical deductible is met
Outpatient Hospital *Anthem's maximum payment is up to $380 per admission for Out-of-Network providers.*	10% coinsurance	50% coinsurance after medical deductible is met
Dialysis/Hemodialysis office and outpatient hospital	10% coinsurance	50% coinsurance after medical deductible is met
Chemo/Radiation Therapy office and outpatient hospital	10% coinsurance	50% coinsurance after medical deductible is met
Skilled Nursing Care (in a facility) *Coverage for Skilled Nursing and Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is limited to 100 days combined per benefit period. Anthem's maximum payment is up to $150 per day for admissions to Out-of-Network providers.*	10% coinsurance	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Inpatient Hospice	No charge	50% coinsurance after medical deductible is met
Durable Medical Equipment	50% coinsurance	50% coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable	Not covered
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with In-Network medical out-of-pocket limit	Not covered
Prescription Drug Coverage **Network:** ***Rx Choice Tiered Network*** **Drug List:** ***Select*** *Drugs not included on the Select drug list will not be covered. Prescription Drugs that we are required to cover by federal law under the "Preventive Care" benefit will be covered with no deductible, copayments or coinsurance when you use an In-Network Pharmacy.*			
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (cost shares noted below)* **Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below). Maintenance medications are available through our home delivery pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.* **Specialty Pharmacy** *30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.*			
Tier 1 - Typically Generic *Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies.*	$5 copay per prescription (retail) and $10 copay per prescription (home delivery)	$15 copay per prescription (retail only)	Not covered (retail and home delivery)
Tier 2 - Typically Preferred Brand *Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies.*	$30 copay per prescription (retail) and $75 copay per prescription (home delivery)	$40 copay per prescription (retail only)	Not covered (retail and home delivery)
Tier 3 - Typically Non-Preferred Brand *Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies.*	$50 copay per prescription (retail) and $125 copay per prescription (home delivery)	$60 copay per prescription (retail only)	Not covered (retail and home delivery)
Tier 4 - Typically Specialty (brand and generic)	30% coinsurance up to $250 per prescription (retail and home delivery)	40% coinsurance up to $250 per prescription (retail only)	Not covered (retail and home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
This is a brief outline of your vision coverage. Not all cost shares for covered services are shown below. Benefits include coverage for member's choice of eyeglass lenses or contact lenses, but not both. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail. Only children's vision services count towards your out-of-pocket limit.		
Children's Vision Essential Health Benefits (up to age 19)		
Child Vision Deductible	Not applicable	Not applicable
Vision Exam *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 exam per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Frames *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Single Vision Lenses *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Bifocal Vision Lenses *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Trifocal Vision Lenses *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Elective Contact Lenses *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Non-Elective Contact Lenses *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Adult Vision (age 19 and older)		
Adult Vision Deductible	Not applicable	Not applicable
Vision Exam *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 exam per benefit period.*	$20 copay	Reimbursed Up to $30
Frames	Not covered	Not covered
Single Vision Lenses	Not covered	Not covered
Bifocal Vision Lenses	Not covered	Not covered
Trifocal Vision Lenses	Not covered	Not covered
Elective Contact Lenses	Not covered	Not covered
Non-Elective Contact Lenses	Not covered	Not covered

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
This is a brief outline of your dental coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail. Only children's dental services count towards your out-of-pocket limit.		
Children's Dental Essential Health Benefits **Diagnostic and preventive** *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 visit per 6 months.*	No charge	No charge
Basic services	20% coinsurance	20% coinsurance dental deductible does not apply
Major services	50% coinsurance	50% coinsurance dental deductible does not apply
Medically Necessary Orthodontia services	50% coinsurance	50% coinsurance dental deductible does not apply
Cosmetic Orthodontia services	Not covered	Not covered
Deductible	$0	$0
Adult Dental **Diagnostic and preventive**	Not covered	Not covered
Basic services	Not covered	Not covered
Major services	Not covered	Not covered
Deductible	Not covered	Not covered
Annual maximum	Not covered	Not covered

Notes:

- Benefit period refers to calendar year.
- For additional information on this plan, please visit www.sbc.anthem.com to obtain a "Summary of Benefits and Coverage".
- If services are rendered by a non-participating provider and your plan includes Out-of-Network benefits, you may be responsible for any difference between the covered plan payment and the actual non-participating provider's charge.
- For plans with an office visit copay, the copay applies to the actual office visit and additional cost shares may apply for any other service performed in the office (i.e., X-ray, lab, surgery), after any applicable deductible.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.
- Certain services are subject to the utilization review program or precertification. Before scheduling services, the member must make sure utilization or precertification review is obtained. If utilization or precertification review is not obtained, benefits may be reduced or not paid according to the plan.
- You must get certain covered transplant procedures from an Approved In-Network Provider to receive the In-Network level of benefits.
- Coverage includes standard fertility preservation services as a basic healthcare service including but are not limited to, injections, cryopreservation and storage for both male and female members when a medically necessary treatment may cause iatrogenic infertility. Member cost share for fertility preservation services is based on provider type and service rendered.
- This health plan includes an Employee Assistance Program (EAP) to support your emotional health and wellness with work life resources, including one-on-one counseling by phone, in person and online. Three counseling visits are available at no charge to a member. EAP member service is accessible 24/7/365.

Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

Questions: (855) 383-7248 or visit us at www.anthem.com/ca
CA/SG/Anthem Platinum PPO 15/40/10%/94HX/2026

Get help in your language

Language Assistance Services

Curious to know what all this says?
We would be too. Here's the English version:
IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (TTY/TDD:711)

Separate from our language assistance program, we make documents available in alternative formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish

IMPORTANTE: ¿Puede leer esta carta?
Si no, podemos pedirle a alguien que le ayude a leerla. También es posible que pueda solicitar que le enviemos esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721 (TTY/TDD: 711).

Arabic

هام: هل تستطيع قراءة هذه الرسالة؟ إذا لم يكن الأمر كذلك، يمكننا أن نطلب من شخص ما مساعدتك في قراءتها. قد تتمكن أيضًا من الحصول على هذه الرسالة مكتوبة بلغتك. للحصول على مساعدة مجانية، يرجى الاتصال على الفور على الرقم
1-888-254-2721. (TTY/TDD: 711)

Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք կարդալ այս նամակը: Եթե ոչ, մենք կարող ենք առաջարկել որևէ մեկի օգնությունը՝ ձեզ համար այն կարդալու համար: Դուք կարող եք նաև այս նամակը ստանալ ձեր լեզվով: Անվճար օգնության համար խնդրում ենք անմիջապես զանգահարել՝ 1-888-254-2721. (TTY/TDD: 711)

Chinese

重要：您能看此信嗎？如果不能，我們可以請人幫您看。 您還可以獲得以您的語言寫的此信件。如需免費幫助，請立即致電 1-888-254-2721. (TTY/TDD:711)

Farsi

مهم: آیا می توانید این نامه را بخوانید؟ اگر نمی توانید، ما می توانیم از شخصی بخواهیم در خواندن آن به شما کمک کند. همچنین ممکن است بتوانید این نامه را به صورت کتبی و به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، لطفاً فوراً با شماره 1-888-254-2721. (TTY/TDD: 711) تماس بگیرید.

Hindi

महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में किसी की मदद ले सकते हैं। यह पत्र आप अपनी भाषा में भी लिखवा सकते हैं। निःशुल्क सहायता के लिए, कृपया तुरंत 1-888-254-2721 पर कॉल करें। (टीटीवाई/टीडीडी:711)

Hmong

TSEEM CEEB: Koj puas nyeem tau daim ntawv no? Yog tias tsis tau, peb muaj qee tus neeg pab nyeem nws rau koj. Koj los kuj yuav tau txais ib daim ntawv sau ua kom yam lus. Rau kev pab dawb, thov hu tam sim ntawm 1-888-254-2721. (TTY/TDD: 711)

Japanese

重要：この文書を読むことができますか？読むことができない場合、支援することが可能です。また、日本語で訳されたこの文書を書面で受け取ることができます。無料の支援をご希望の場合、1-888-254-2721（TTY/TDD:711）にご連絡ください。

Khmner

សំខាន់ៈ តើអ្នកអាចអានសំបុត្រនេះបានទេ? បើអត់ទេ យើងអាចមានអ្នកជួយអាន។ អ្នកក៏អាចទទួលបានសំបុត្រនេះសរសេរជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមទូរស័ព្ទមកភ្លាមៗតាមរយៈលេខ
1-888-254-2721. (TTY/TDD: 711)

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Korean

중요: 이 편지를 읽으실 수 있으신가요? 그렇지 않으신 경우, 이를 읽으실 수 있도록 도움을 제공해 드릴 수 있습니다. 귀하의 모국어로 된 편지를 우편으로 받아보실 수도 있습니다. 무상으로 제공되는 도움이 필요하신 경우, 1-888-254-2721번으로 바로 연락해 주십시오. (TTY/TDD: 711)

Punjabi

ਕੀ ਤੁਸੀ ਇਹ ਚਿੱਠੀ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀ, ਤਾਂ ਅਸੀ ਇਸਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਸ ਚਿੱਠੀ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਵੀ ਲਿਖ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਤੁਰੰਤ ਇਸ 'ਤੇ ਕਾਲ ਕਰੋ 1-888-254-2721। (TTY/TDD: 711)

Russian

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

Tagalog

MAHALAGA: Mababasa mo ba ang sulat na ito? Kung hindi, mayroon kaming makakatulong sa iyo na basahin ito. Maaari mo ring makuha ang sulat na ito nang nakasulat sa iyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

Thai

สำคัญ: คุณสามารถอ่านจดหมายนี้ได้หรือไม่ หากคุณอ่านจดหมายนี้ไม่ได้ เราสามารถขอให้ใครสักคนช่วยคุณอ่านได้ คุณสามารถร้องขอจดหมายนี้ที่เขียนในภาษาของคุณได้เช่นกัน หากต้องการความช่วยเหลือแบบไม่มีค่าใช้จ่าย โปรดโทรหาเราได้ทันทีที่ 1-888-254-2721. (TTY/TDD: 711)

Vietnamese

QUAN TRỌNG: Quý vị có đọc được lá thư này không? Nếu không, chúng tôi có thể nhờ ai đó giúp quý vị đọc. Quý vị cũng có thể yêu cầu thư này viết bằng ngôn ngữ của quý vị. Để được trợ giúp miễn phí, hãy gọi ngay đến số 1-888-254-2721. (TTY/TDD: 711)

It's important we treat you fairly

We follow state and federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services, in a timely manner, like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279, or if you think you were discriminated against based on race, color, national origin, age, disability, or sex, you can mail a complaint directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

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