

Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your 2026 Contract Code: 958C

Your Plan: Anthem Bronze Choice PPO 6000/25%/8000 w/HSA

Your Network: Choice 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	25% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	\$6,000 person / \$12,000 family	\$6,500 person / \$13,000 family	\$13,000 person / \$26,000 family
Overall Out-of-Pocket Limit <i>When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period.</i>	\$8,000 person / \$16,000 family	\$8,000 person / \$16,000 family	\$16,000 person / \$32,000 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 deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.

The deductibles for Preferred Network and In-Network do not cross apply. The out-of-pocket limits for Preferred Network and In-Network cross apply, meaning satisfying one helps satisfy the other.

All medical services subject to a coinsurance are also subject to the annual medical deductible.

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).

Covered Medical Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Primary Care (PCP) and Mental Health and Substance Use Disorder Services <i>virtual and office</i>	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Specialist Provider <i>virtual and office</i>	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Other Practitioner Visits Maternity Doctor services (prenatal/postpartum care and delivery) <i>Preferred Network and In-Network preventive prenatal and postpartum services are covered at 100%.</i> Retail Health Clinic Spinal Manipulation <i>Coverage is limited to 50 visits per benefit period.</i> Acupuncture	25% coinsurance after deductible is met 25% coinsurance after deductible is met 25% coinsurance after deductible is met Not covered	40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met Not covered	50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met Not covered
Other Services in an Office Allergy Testing Prescription Drugs - Dispensed in the office <i>For the drugs itself dispensed in the office through infusion/injection.</i> Surgery	25% coinsurance after deductible is met 25% coinsurance after deductible is met 25% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	No charge	50% coinsurance after deductible is met
Preventive care for Chronic Conditions <i>per IRS guidelines</i>	No charge	No charge	Cost share is based on the setting services are received.
<u>Diagnostic Services Lab</u> Office	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Freestanding Lab/Reference Lab	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
<u>Diagnostic Services X-Ray</u>			
Office	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
<u>Diagnostic Services Advanced Diagnostic Imaging</u> - for example: MRI, PET and CAT scans			
Office	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
<u>Emergency and Urgent Care</u>			
Urgent Care (Office Setting)	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency Room Facility Services	25% coinsurance after deductible is met	25% coinsurance after deductible is met	Same as In-Network Tier 1
Emergency Room Doctor and Other Services	25% coinsurance after deductible is met	25% coinsurance after deductible is met	Same as In-Network Tier 1
Ambulance (Air and Ground)	25% coinsurance after deductible is met	25% coinsurance after deductible is met	Same as In-Network Tier 1

Covered Medical Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<i>Authorized Out-of-Network non-emergency ambulance services are limited to an Anthem maximum payment of \$50,000 per trip. The \$50,000 limit does not apply to air ambulance services.</i>			
<u>Outpatient Mental Health and Substance Use Disorder Services at a Facility</u> Facility Fees Doctor Services	25% coinsurance after deductible is met 25% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met
<u>Outpatient Surgery</u> Facility Fees Hospital Ambulatory Surgical Center Physician and other services including surgeon fees Hospital Ambulatory Surgical Center	25% coinsurance after deductible is met 25% coinsurance after deductible is met 25% coinsurance after deductible is met 25% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after 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) <i>Coverage for Inpatient Rehabilitation is limited to 120 days per benefit period.</i> Physician and other services including surgeon fees	25% coinsurance after deductible is met 25% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<u>Home Health Care</u>	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
<u>Therapy Services</u> Rehabilitation services (for example, physical/speech/occupational therapy) <i>Coverage for physical therapy, occupational therapy and speech therapy is limited to 120 visits combined per benefit period.</i> Office Outpatient Hospital	25% coinsurance after deductible is met 25% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met
Habilitation services (for example, physical/speech/occupational therapy) <i>Coverage for physical therapy, occupational therapy and speech therapy is limited to 120 visits combined per benefit period.</i> Office Outpatient Hospital	25% coinsurance after deductible is met 25% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met
Pulmonary rehabilitation office and outpatient hospital	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Cardiac rehabilitation office and outpatient hospital	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Dialysis/Hemodialysis office and outpatient hospital	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Chemo/Radiation Therapy office and outpatient hospital	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (in a facility) <i>Coverage is limited to 150 days per benefit period. Limit is combined across a skilled nursing facility and an outpatient day rehabilitation program.</i>	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Inpatient Hospice	No charge after deductible is met	No charge after deductible is met	50% coinsurance after deductible is met
Durable Medical Equipment	50% coinsurance after deductible is met	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period. Coverage for hearing aids and services is limited to 1 item per ear every 3 years.</i>	50% coinsurance after deductible is met	50% coinsurance after deductible is met	50% coinsurance after 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	Combined with Preferred Network medical deductible	Combined with Preferred Network medical deductible	Combined with Out-of-Network medical deductible
Pharmacy Out-of-Pocket Limit	Combined with Preferred Network medical out-of-pocket limit	Combined with Preferred Network medical out-of-pocket limit	Combined with Out-of-Network medical out-of-pocket limit
Prescription Drug Coverage Network: Rx Choice Tiered Network Drug List: Select <i>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.</i>			
Day Supply Limits: Retail Pharmacy <i>30 day supply (cost shares noted below)</i> Retail 90 Pharmacy <i>90 day supply (cost shares noted below)</i> Home Delivery Pharmacy <i>90 day supply (maximum cost shares noted below). Maintenance medications are available through our home delivery pharmacy. You may get two 30-day supply fills of the same maintenance medication at a retail pharmacy. Prior to your 3rd fill, you must call us on the number on your ID card and tell us if you would like to keep getting your maintenance medications from a retail pharmacy or if you would like to use home delivery. If you do not contact us, you will pay the full retail cost of any maintenance medication until you inform us of your decision.</i> Specialty Pharmacy <i>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.</i>			
Preventive Drugs <i>The deductible does not apply to prescription drugs on the PreventiveRx Plus drug list when you use a Preferred Network or an In-Network Pharmacy.</i>			
Tier 1 - Typically Generic	25% coinsurance after deductible is met (retail and home delivery)	35% coinsurance after deductible is met (retail only)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 2 - Typically Preferred Brand	25% coinsurance after deductible is met (retail and home delivery)	35% coinsurance after deductible is met (retail only)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	25% coinsurance after deductible is met (retail and home delivery)	35% coinsurance after deductible is met (retail only)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	25% coinsurance after deductible is met (retail and home delivery)	35% coinsurance after deductible is met (retail only)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<i>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.</i>		
Children's Vision Essential Health Benefits (up to age 19)		
Child Vision Deductible	Not applicable	Not applicable
Vision Exam <i>Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 exam per benefit period.</i>	No charge	Not covered
Frames <i>Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.</i>	No charge	Not covered
Single Vision Lenses <i>Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.</i>	No charge	Not covered
Bifocal Vision Lenses <i>Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.</i>	No charge	Not covered
Trifocal Vision Lenses <i>Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.</i>	No charge	Not covered
Elective Contact Lenses <i>Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.</i>	No charge	Not covered
Non-Elective Contact Lenses <i>Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.</i>	No charge	Not covered
Adult Vision (age 19 and older)		
Adult Vision Deductible	Not applicable	Not applicable
Vision Exam <i>Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 exam per benefit period.</i>	\$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
<i>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.</i>		
Children's Dental Essential Health Benefits		
Diagnostic and preventive <i>Coverage for In-Network Providers and Out-of-Network Providers is limited to 2 visits per 12 months.</i>	No charge	30% coinsurance deductible does not apply
Basic services	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Major services	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Medically Necessary Orthodontia services	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Cosmetic Orthodontia services	Not covered	Not covered
Deductible	Combined with medical deductible	Combined with medical deductible
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

Healthy Support & Rewards

To see your rewards and additional information log into the Anthem website at [anthem.com](https://www.anthem.com) or call the customer service number on your member ID card.

Program Name	Program Description	Program Incentive
Smart Rewards (Wellbeing Solutions Engagement Package 200)	Subscriber and spouse/domestic partner may earn rewards when eligible activities are completed and, in some instances, are verified by an Anthem claim.	Up to \$200 per member per year

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”.
- When you receive services from an Out-of-Network Provider and your plan includes Out-of-Network benefits, you may be required to pay (i) the difference between any amount the plan pays and the provider charges for services (balance billing) in addition to (ii) any applicable copayments, co-insurance, and/or deductibles. This does not apply when you receive emergency services or as otherwise required by law; in such cases, you will only be responsible for any applicable copayments, co-insurance, and/or deductibles.
- To get the highest benefits at the lowest Out-of-Pocket cost, you must get Covered Services from an In-Network Provider. Benefits for Covered Services are based on the Maximum Allowed Amount, which is the most the Plan will allow for a Covered Service. Except for emergency services received or as otherwise required by law, when you use an Out-of-Network Provider you may have to pay the difference between the Out-of-Network Provider’s billed charge and the Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges. This amount can be substantial. Please review the Evidence of Coverage (EOC) for more details.
- 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.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.
- Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, 3D mammography, breast ultrasounds and MRIs are covered in full after deductible as required by state mandate.
- 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.

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Questions: (855) 330-1218 or visit us at www.anthem.com

NV/SG/Anthem Bronze Choice PPO 6000/25%/8000 w/HSA/958C/2026

We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

Spanish

Usted tiene derecho a obtener asistencia en su idioma sin cargo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación ¿Tiene alguna deficiencia visual? También puede solicitar este documento en otros formatos.

Chinese

您有權免費獲得使用您的語言提供的協助。只需撥打印於您的 ID 卡上的會員服務部電話號碼即可。視力障礙？您也可以索取本文件的其他格式。

Vietnamese

Quý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, miễn phí. Quý vị chỉ cần gọi đến số điện thoại của Ban Dịch vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm thị? Quý vị cũng có thể yêu cầu các định dạng khác của tài liệu này.

Korean

귀하는 귀하의 언어로 된 도움을 무료로 받을 권리가 있습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로 전화하십시오. 시각 장애인인가요? 다른 형식으로 된 이 문서를 요청하실 수 있습니다.

Tagalog

May karapatan kang makakuha ng tulong na nasa iyong wika nang libre. Tawagan lang ang numero ng Member Services na nasa iyong ID card. May kapansanan sa paningin? Maaari ka ring humingi ng iba pang mga format ng dokumentong ito.

Russian

У вас есть право на бесплатное получение помощи на вашем родном языке. Просто позвоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. У вас проблемы со зрением? Вы также можете запросить этот документ в других форматах.

French Creole

Ou gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo Sèvis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? Ou ka mande tou pou lòt fòm nan dokiman sa a.

Arabic

لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجاناً. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضاً طلب تنسيقات أخرى لهذه الوثيقة.

French

Vous avez le droit d'obtenir de l'aide dans votre langue gratuitement. Appelez simplement le numéro du Services membres figurant sur votre carte d'identité. Vous êtes une personne malvoyante ? Vous pouvez également demander à accéder à ce document dans d'autres formats.

Persian

شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره خدمات اعضا مندرج در کارت عضویت خود تماس بگیرید. آیا دچار اختلال بینایی هستید؟ همچنین می‌توانید فرمت‌های دیگر این سند را درخواست کنید.

Armenian

Դուք իրավունք ունեք անվճար օգնություն ստանալու ձեր լեզվով: Դարգապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցող եք: Կարող եք նաև խնդրել այս փաստաթղթի այլ ձևաչափեր:

Japanese

あなたにはあなたの言語で無料で支援を受ける権利があります。ID カードに記載されている会員サービス番号にお電話ください。視覚障害をお持ちですか？他の形式でこの文書を要求することもできます。

Italian

Hai il diritto di ricevere assistenza gratuita nella tua lingua. Basta chiamare il numero del Servizio Membri presente sulla tua tessera identificativa. Hai problemi di vista? È possibile richiedere anche altri formati di questo documento.

German

Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Rufen Sie einfach die Nummer des Mitgliederservices auf Ihrer ID-Karte an. Sehbehindert? Sie können dieses Dokument auch in anderen Formaten anfordern.

Polish

Masz prawo do bezpłatnej pomocy w swoim języku. Wystarczy zadzwonić pod numer Biura Obsługi Klienta podany na karcie identyfikacyjnej. Masz wadę wzroku? Możesz również poprosić o inne formaty tego dokumentu.

Pennsylvania Dutch

Du hoscht's Recht fer Hilf griege in dei Schprooch fer nix. Duh yuscht die Member Services Number uffrufe uff dei ID Card. Hoscht Druwwel fer sehne? Du kannscht des do Schreiwes in en differnter Weg griege so as du's besser sehne kannscht.

TTY/TTD:711

It's important we treat you fairly

We follow 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, sex, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services 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 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>