CareExtra (HMO)
H1019-097

2019



SUMMARY OF BENEFITS

South Florida:

Broward, Palm Beach

CarePlus HEALTH PLANS

H1019_MKSB0972019_M

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules.

If you have any questions, you can call and speak to a Member Services representative at **1-800-794-4105** (TTY: **711**). From October 1 - March 31, we are open 7 days a week; 8:00 a.m. to 8:00 p.m. From April 1 - September 30, we are open Monday - Friday; 8:00 a.m. to 8:00 p.m. You may always leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within 1 business day.

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor.
  Visit **www.careplushealthplans.com/medicare-plans/2019** or call **1-800-794-4105** (TTY: **711**) to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2020.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

2019 Summary of Benefits

This Summary of Benefits booklet gives you a summary of what **CareExtra (HMO)** covers and what you pay. It does not list every service covered by this plan or list every limitation or exclusion. To get a complete list of services covered by this plan, please call us and ask for our Evidence of Coverage (EOC) document or you can see it on our website: www.careplushealthplans.com/medicare-plans/2019.
An EOC is automatically mailed to you after you enroll in our plan.

Tips for comparing your Medicare choices

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets, or use the Medicare Plan Finder on **www.medicare.gov**.
- If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. You can view it online at **www.medicare.gov** or get a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

Who can join CareExtra (HMO)?

To join **CareExtra (HMO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area includes the following county in Florida: Broward and Palm Beach.



Which doctors, hospitals, and pharmacies can you use?

CareExtra (HMO) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services. **Prior authorization or a physician referral may be required for covered in-network medical services.**

You must generally use network pharmacies to fill your prescriptions for Medicare-covered drugs (Part D drugs). Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies.

You can see our plan's provider/pharmacy directory on our website: www.careplushealthplans.com/directories.

You can also call us and we will send you a copy of the provider/pharmacy directory.

What does this plan cover?

CareExtra (HMO) covers everything that Original Medicare covers - and *more*.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider. For more information on Part B covered drugs, refer to the Evidence of Coverage (EOC).

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, www.careplushealthplans.com/medicare-plans/2019-prescription-drug-guides.

You can also call us and we will send you a copy of the formulary.

How to determine your drug costs

The plan groups medications into one of five "tiers". You will need to use your formulary to locate what tier your drug is in to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the drug coverage you have reached.

Do you have Medicare and Medicaid? If you are a dual-eligible beneficiary enrolled in both Medicare and Florida's Medicaid program, **you may not have to pay the medical costs displayed in this booklet and your prescription drug costs will be lower, too**. Please contact us to learn more about how this plan works for dual-eligible members.

How to reach us

For more information, please call the phone numbers listed below or visit us at **www.careplushealthplans.com**.

If you are a member of this plan, reach out to a Member Services representative by calling toll-free **1-800-794-5907** (TTY: **711**).	**If you are not a member** of this plan, reach out to a licensed sales agent by calling toll-free **1-800-794-4105** (TTY: **711**).

From October 1 - March 31, we are open 7 days a week; 8:00 a.m. to 8:00 p.m.

From April 1 - September 30, we are open Monday - Friday; 8:00 a.m. to 8:00 p.m.

You may always leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within 1 business day.

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MONTHLY PREMIUM, DEDUCTIBLE, AND MAXIMUM OUT-OF-POCKET LIMIT

Monthly Plan Premium

- **$11.90**
- If you receive "Extra Help" from Medicare, depending on the level of "Extra Help" you receive, the plan premium may be reduced to **$0**.
- You must continue to pay your Medicare Part B premium. The Part B premium may be covered through your State Medicaid Program.

Deductible

- **$0** - This plan does not have a deductible for medical services.

Maximum Out-of-Pocket Limit

- **$1,500** per year.
- This amount is the most you will pay during the plan year for approved medical services under our plan. Once you have paid this amount, we pay 100% of your covered services for the rest of the year, excluding any prescription drug costs, health expenses incurred during foreign travel, or supplemental benefit costs.

COVERED MEDICAL AND HOSPITAL BENEFITS

Inpatient Hospital Care

- **$50** copay per day for days **1** through **5**.
- **$0** copay per day for days **6** through **90**.
- **$0** copay per day for days **91** and beyond.
- Our plan covers an **unlimited** number of days for an inpatient hospital stay.

Outpatient Hospital Care

- **$0** copay for lab services.
- **$5** copay for:
  - Mental health care group and individual therapy visits.
  - Physical therapy, occupational therapy, speech and language therapy.
  - Cardiac and pulmonary rehabilitation services.
  - Supervised Exercise Therapy (SET) services.
- **$40** copay for:
  - Diagnostic procedures and tests.
  - Basic radiology (X-ray) services.
  - Diagnostic radiology services (including advanced imaging services such as MRI, MRA and CT scans).
  - Therapeutic radiology (radiation therapy) services.
  - Diagnostic mammography services.
  - Nuclear medicine services.
  - Diagnostic colonoscopy services.
  - Surgery services.
- **20%** coinsurance for:
  - Chemotherapy drugs.
  - Renal dialysis.

Doctor Visits

- **$0** copay for primary care physician (PCP) visits.
  – You must select an in-network physician as your PCP. The PCP that you choose will focus on your needs and coordinate your care with other network providers.
- **$5** copay for specialist visits.

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Preventive Care

- **$0** copay
- Our plan covers many preventive services, including:
  - Abdominal aortic aneurysm screening
  - Alcohol misuse screening and counseling
  - Annual Wellness Visit (AWV)
  - Bone mass measurement
  - Breast cancer screening (mammogram)
  - Cardiovascular disease risk reduction visit
  - Cardiovascular disease screening
  - Cervical and vaginal cancer screenings (pap tests, pelvic exams, HPV tests)
  - Colorectal cancer screening (i.e. colonoscopy, fecal occult blood test, flexible sigmoidoscopy)
  - Depression screening
  - Diabetes screening
  - Diabetes self-management training
  - Glaucoma screening
  - Hepatitis B virus (HBV) screening
  - Hepatitis C virus (HCV) screening
  - HIV screening
  - Lung cancer screening
  - Medical nutrition therapy services
  - Medicare Diabetes Prevention Program (MDPP)
  - Obesity screening and therapy
  - Prostate cancer screening
  - Screening for sexually transmitted infections (STIs) and counseling
  - Tobacco use cessation counseling
  - Vaccines including Influenza (Flu), Hepatitis B Virus (HBV), Pneumococcal
  - "Welcome to Medicare" preventive visit (one-time)
- Any additional preventive services approved by Medicare during the contract year will be covered.

Emergency Care

- **$120** copay for facility.
- **$0** copay for physician and professional services.
- Emergency coverage is the same world-wide except, if you receive emergency care (in-area, out-of-area, or after-hours) and pay for covered services, we will reimburse you for our share of the cost up to the Medicare allowable charge.
- You do not pay the emergency care copay if you're admitted to the same hospital within 24 hours for the same condition.

Urgently Needed Services

- **$0** copay at your primary care physician's office.
- **$5** copay at a specialist's office.
- **$5** copay at an urgent care center.
- Coverage for urgently needed services is the same world-wide except, if you receive urgently needed care (in-area, out-of-area, or after-hours) and pay for covered services, we will reimburse you for our share of the cost up to the Medicare allowable charge.

Diagnostic Services

- **Diagnostic procedures and tests:**
  – **$0** copay at your primary care physician's office
  – **$5** copay at a specialist's office
  – **$5** copay at an urgent care center
  – **$40** copay at a hospital facility as an outpatient
- **Basic radiology (X-ray) services:**
  – **$0** copay at your primary care physician's office
  – **$0** copay at a specialist's office
  – **$0** copay at an urgent care center
  – **$0** copay at a freestanding radiological facility
  – **$40** copay at a hospital facility as an outpatient
- **Diagnostic radiology services** (includes advanced imaging services such as MRI, MRA and CT Scans)**:**
  – **$30** copay at your primary care physician's office
  – **$30** copay at a specialist's office
  – **$30** copay at a freestanding radiological facility
  – **$40** copay at a hospital facility as an outpatient
- **Therapeutic radiology (radiation therapy) services:**
  – **$30** copay at a specialist's office
  – **$30** copay at a freestanding radiological facility
  – **$40** copay at a hospital facility as an outpatient
- **Lab services:**
  – **$0** copay
- **Diagnostic mammography services:**
  – **$0** copay at a specialist's office
  – **$0** copay at a freestanding radiological facility
  – **$40** copay at a hospital facility as an outpatient
- **Diagnostic colonoscopy services:**
  – **$5** copay at a specialist's office
  – **$30** copay at an ambulatory surgical center
  – **$40** copay at a hospital facility as an outpatient
- **Nuclear medicine services:**
  – **$30** copay at a freestanding radiological facility
  – **$40** copay at a hospital facility as an outpatient

Hearing Services

- **$5** copay for an exam to diagnose and treat hearing and balance issues.
- **$0** copay for routine hearing exam (for up to **1** every year).
- **$0** copay for hearing aid fitting/evaluation (for up to **1** every year).
- Our plan covers up to **$500** per ear, every year for hearing aids.
- **1** month battery supply and **2**-year warranty included.

Dental Services

- **$5** copay for limited Medicare-covered dental services. Excludes preventive, restoration, removal and replacement services.
- **$0** copay for the following supplemental dental services:
  – Periodic oral evaluation(s), up to **2** per calendar year
  – Comprehensive oral evaluation, up to **1** every **3** calendar years
  – Prophylaxis cleaning(s), up to **2** per calendar year
  – Bitewing X-rays, up to **1** set(s) per calendar year
  – Panoramic X-ray film, up to **1** per calendar year
  – Amalgam or resin filling(s), up to **2** per calendar year
  – Scaling and root planing (deep cleaning), up to **1** per quadrant per calendar year
  – Simple or surgical extractions, up to **3** per calendar year
  – Denture reline, up to **1** per calendar year
  – Complete or partial dentures (upper and/or lower), up to **1** set every **5** calendar years
  – Anesthesia
- Total periodic and comprehensive oral evaluations limited to **2** per calendar year.
- You must visit a participating dental network provider to receive dental benefits. Please refer to the plan's Provider Directory for the names and locations of participating providers in your area.

Vision Services

- **$5** copay for eye exams to diagnose and treat diseases and conditions of the eye.
- **$0** copay for diabetic eye exam.
- **$0** copay for **1** pair of eyeglasses (frames and lenses) or contact lenses after cataract surgery.
- Supplemental vision services:
  - **$0** copay for supplemental routine eye exams with refraction, up to **1** per calendar year.
  - Our plan also pays up to **$250** per calendar year for contact lenses or eyeglasses (frames and lenses) of your choice; OR, you may choose **2** free pairs of eyeglasses from a pre-determined selection.
  - Ultraviolet protection and scratch resistant coating included on eyeglasses.
  - Fitting included for all eyewear.
  - If total cost is more than what our plan covers, you are responsible for the difference.

Mental Health Care

- **Inpatient visit - general hospital:**
  - **$50** copay per day for days **1** through **5**.
  - **$0** copay per day for days **6** through **90**.
  - Our plan covers up to 90 days per stay in a general hospital.
  - Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. Once you have used up these extra 60 days, your coverage for a current stay ends and coverage for each future hospital stay ends after 90 days.
- **Inpatient visit - psychiatric facility:**
  - **$50** copay per day for days **1** through **5**.
  - **$0** copay per day for days **6** through **90**.
  - Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital.
- **Outpatient visit**
  - **$5** copay for outpatient group and individual therapy visits.
  - **$5** copay for partial hospitalization.
  - Includes outpatient treatment for mental illness and/or substance abuse.

Skilled Nursing Facility (SNF)

- **$0** copay per day for days **1** through **20**.
- **$172** copay per day for days **21** through **100**.
- No prior hospital stay is required.
- Our plan covers up to **100** days in a SNF per benefit period.
- A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient hospital care or skilled care in a SNF for 60 days in a row. If you go into a hospital or SNF after one benefit period has ended, a new benefit period begins. There's no limit to the number of benefit periods.

Physical Therapy

- **$5** copay per visit.

Ambulance

- **$0** copay per trip for emergency ambulance services by ground transportation.
- **$0** copay per trip for non-emergency ambulance services by ground transportation.

Routine Transportation

- **$0** copay for **unlimited** one-way trip(s) per calendar year.
- Transportation provided by contracted vendor to plan-approved locations.

Medicare Part B Drugs

- **Part B drugs purchased at a pharmacy, provided in a physician's office, or provided in a hospital facility as an outpatient:**
  – **20%** coinsurance
  – **$0** copay for allergy injections provided in a physician's office.
- **Chemotherapy drugs:**
  – **20%** coinsurance

PART D PRESCRIPTION DRUG BENEFITS

- This plan offers nationwide in-network prescription coverage.
- This plan uses a formulary. Quantity limitations and other drug restrictions/authorizations may apply.
- You may get your drugs at network retail pharmacies and network mail-order pharmacies.
- Total yearly drug costs are the total drug costs paid by both you and the plan.
- Our network includes pharmacies that offer standard cost-sharing and pharmacies that offer preferred cost-sharing. Your cost may be less at pharmacies with preferred cost-sharing.

Deductible

- **$415** annual deductible.

Initial Coverage

- You pay the following until your total yearly drug costs reach **$3,820**.

Tier	Preferred Retail Cost-Sharing	Standard Retail Cost-Sharing	Preferred Mail-Order Cost-Sharing	Standard Mail-Order Cost-Sharing
Tier 1 Preferred Generic Drugs	**24%** coinsurance for 30-day and 90-day supplies.	**25%** coinsurance for 30-day and 90-day supplies.	**24%** coinsurance for 30-day and 90-day supplies.	**25%** coinsurance for 30-day and 90-day supplies.
Tier 2 Generic Drugs	**24%** coinsurance for 30-day and 90-day supplies.	**25%** coinsurance for 30-day and 90-day supplies.	**24%** coinsurance for 30-day and 90-day supplies.	**25%** coinsurance for 30-day and 90-day supplies.
Tier 3 Preferred Brand Drugs	**24%** coinsurance for 30-day and 90-day supplies.	**25%** coinsurance for 30-day and 90-day supplies.	**24%** coinsurance for 30-day and 90-day supplies.	**25%** coinsurance for 30-day and 90-day supplies.
Tier 4 Non-Preferred Drugs	**24%** coinsurance for 30-day and 90-day supplies.	**25%** coinsurance for 30-day and 90-day supplies.	**24%** coinsurance for 30-day and 90-day supplies.	**25%** coinsurance for 30-day and 90-day supplies.
Tier 5 Specialty Tier Drugs	**25%** coinsurance for 30-day supply. Not offered for 90-day supply.	**25%** coinsurance for 30-day supply. Not offered for 90-day supply.	**25%** coinsurance for 30-day supply. Not offered for 90-day supply.	**25%** coinsurance for 30-day supply. Not offered for 90-day supply.

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Coverage Gap

- After your total yearly drug costs (what you and the plan pay) reach **$3,820**, you enter the coverage gap.
- All medication is **100%** member responsibility during the coverage gap, less any applicable Part D coverage gap discounts.
- While you are in the Coverage Gap, you pay only **25%** of the cost for brand-name drugs and **37%** of the cost for generic drugs based on the plan's contracted rates through retail and mail-order pharmacies.

Catastrophic Coverage

- After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$5,100**, you pay the greater of:
  – **5%** of the cost, or
  – **$3.40** copay for generic (including brand drugs treated as generic) and a **$8.50** copay for all other drugs.
- Your yearly out-of-pocket drug costs is the total of any Part D-covered drug payments made during the calendar year by you, on your behalf, or under another Medicare prescription drug plan before you joined our plan, and determines when you enter the catastrophic coverage phase.

Excluded Part D Drugs Covered by Our Plan

- Certain erectile dysfunction drugs are covered at Tier 1 cost-share.
- Refer to your Evidence of Coverage for specific coverage information including costs.
- These drugs are covered at an in-network retail or mail-order pharmacy and do not apply towards your total annual drug cost.

Additional Prescription Drug Information

- **If you receive "Extra Help" from Medicare, your costs for prescription drugs may be lower than the cost-shares in this booklet. You pay whichever is less.**
- Cost-sharing may change depending on the pharmacy you choose (preferred, non-preferred, mail-order, home infusion, or long term care), the supply needed (30 or 90 days), the phase of the Part D benefit you are in, and if you qualify for "Extra Help." For more information on the pharmacy-specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.
- You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.
- Contact CarePlus to determine if a particular drug is covered or visit: www.careplushealthplans.com/medicare-plans/2019-prescription-drug-guides.

ADDITIONAL COVERED MEDICAL BENEFITS

Outpatient Surgery

- **$0** copay at your primary care physician's office.
- **$5** copay at a specialist's office.
- **$30** copay at an ambulatory surgical center.
- **$40** copay at a hospital facility as an outpatient.

Other Rehabilitation Services

- **Occupational therapy (daily living activities), speech and language therapy:**
  – **$5** copay
- **Cardiac (heart) and pulmonary (lungs) rehabilitation services:**
  – **$5** copay
- **Supervised Exercise Therapy (SET) services:**
  – **$5** copay

Foot Care *(Podiatry Services)*

- **$5** copay for foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.
- **$5** copay for routine foot care.
- You may self-refer to a network podiatrist for **unlimited** routine visits for treatment of flat feet or other structural misalignments of the feet, removal of corns, removal of warts, removal of calluses, and hygienic care.

Medical Equipment/Supplies

- **Durable medical equipment:**
  - **20%** coinsurance for power-operated or customized durable medical equipment (includes electric wheelchairs, scooters, insulin pumps, etc.)
  - **$0** copay for all other durable medical equipment.
- **Prosthetic devices *(braces, artificial limbs, etc.)* and other medical supplies:**
  - **$0** copay for prosthetic devices.
  - **$0** copay for other medical supplies.
- **Diabetic supplies:**
  - **$0** copay for therapeutic shoes and inserts.
- **Diabetic monitoring supplies:**
  - **$0** copay

Wellness Programs

- **Post-hospitalization Meal Program:**
  - **$0** copay
  - After your overnight stay in the hospital or skilled nursing facility, you're eligible for up to **10** nutritious meals delivered to your door at no cost to you. Limited to 4 times per year.
- **SilverSneakers® Fitness Program:**
  - **$0** copay
  - The fitness program includes access to 14,000+ participating locations and signature group exercise classes led by certified instructors. At-home kits are offered for members who want to start working out at home or for those who can't get to a fitness location due to injury, illness or being homebound.
- **24-hour Nurse Advice Line:**
  - **$0** copay
  - Healthcare advice from a registered nurse, 24 hours a day, 7 days a week.
- **Over-the-Counter (OTC) Items:**
  - You are eligible to receive a **$75** monthly allowance toward the purchase of select OTC items such as pain relievers, cough and cold medicines, allergy medications, and first aid/medical supplies when you use the participating mail-order service.
  - Please visit our plan website to see our list of covered OTC items.
  - OTC items may only be ordered for the plan member.
- **CarePlus Rewards:**
  - CarePlus rewards offers members a gift card of their choice from participating retailers for completing preventive screenings and certain other healthcare activities. Some limitations and exclusions apply.
  - In accordance with the federal requirements of the Centers for Medicare & Medicaid Services, no amounts on the gift cards shall be redeemable for cash or be used to purchase Medicare-covered items or services. All rewards (gift cards) must be earned and redeemed prior to the end of the plan year. Rewards not redeemed by 12/31 will be forfeited.

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Chiropractic Care

- **$5** copay for Medicare-covered manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position.)
- **$5** copay for up to **12** self-referred, routine visits to a network chiropractor every year.

Home Health Care

- **$0** copay for limited skilled nursing care and certain other health services you get in your home for the treatment of an illness or injury.
- Number of covered visits is based on medical need as determined by your physician and authorized by the plan.

Hospice Care

- **$0** copay for hospice care from a Medicare-certified hospice.
- You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.

Personal Home Care

- **$0** copay
- With the respite care benefit you will receive services for a minimum of 3 hours per day up to 42 hours per year. Respite care is the provision of certain non-skilled, in-home services by a home health aide in order to provide temporary relief for family members or other persons who normally care for the member in the home, when the member requires assistance with those services as a result of a medical condition.
- Authorization may be required. Contact the plan for details.

Renal Dialysis

- **20%** coinsurance
- **$0** copay for kidney disease education services.

Wigs (related to chemotherapy treatment)

- **$0** copay
- With physician authorization, eligible members may receive up to **$500** reimbursement per calendar year toward the purchase of a wig for medical hair loss related to chemotherapy treatment. Must use network provider(s).

Discrimination is against the law

CarePlus Health Plans, Inc. ("CarePlus") complies with applicable Federal Civil Rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion. CarePlus does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion. CarePlus provides:

- Free assistance and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Video remote interpretation
  - Written information in other formats
- Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call the number on the back of your Member ID Card or contact Member Services using the information below. If you believe that CarePlus has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion, you can file a grievance with:

CarePlus Health Plans, Inc. Attention: Member Services Department. 11430 NW 20th Street, Suite 300. Miami, FL 33172. Telephone: **1-800-794-5907;** (**TTY: 711**). From October 1 - March 31, we are open 7 days a week; 8 a.m. to 8 p.m. From April 1 - September 30, we are open Monday - Friday, 8 a.m. to 8 p.m. You may always leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within 1 business day. Fax: **1-800-956-4288**.

You can file a grievance in person or by mail, phone or fax. If you need help filing a grievance, our Member Services Representatives are available to help you at the contact information listed above.

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**.

Multi-Language Interpreter Services

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-800-794-5907 (TTY: 711).

Español (Spanish): ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-794-5907 (TTY: 711).

繁體中文 (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 1-800-794-5907 (TTY: 711)。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-794-5907 (TTY: 711).

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-794-5907 (TTY: 711) 번으로 전화해 주십시오.

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-794-5907 (TTY: 711).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-794-5907 (телетайп: 711).

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-794-5907 (TTY: 711).

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-794-5907 (ATS : 711).

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-794-5907 (TTY: 711).

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-794-5907 (TTY: 711).

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-794-5907 (TTY: 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-794-5907 (TTY: 711).

ગુજરાતી (Gujarati): સુચના: જો તમે ગુજરાતી બોલતા હો, તો નઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-794-5907 (TTY: 711).

ภาษาไทย (Thai): เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร1-800-794-5907 (TTY: 711).

Diné Bizaad (Navajo): Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, koji' hódíílnih 1-800-794-5907 (TTY: 711).

العربية (Arabic):

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-794-5907 (رقم هاتف الصم والبكم: 711).

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ATENCIÓN: Si usted habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-794-5907 (TYY: 711).