Your summary of benefits

Anthem

Anthem® Blue Cross and Blue Shield

Your 2025 Contract Code: 889B

Your Plan: Anthem Silver Choice PPO 5000/30%/9200

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	$60 copay per visit deductible does not apply

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	$5,000 person / $10,000 family	$6,000 person / $12,000 family	$12,000 person / $24,000 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.*	$9,200 person / $18,400 family	$9,200 person / $18,400 family	$18,400 person / $36,800 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 with the exception of facility emergency room charge.

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
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*	$40 copay per visit deductible does not apply	$50 copay per visit deductible does not apply	50% coinsurance after deductible is met
Specialist Care *virtual and office*	$60 copay per visit deductible does not apply	$90 copay per visit deductible does not apply	50% coinsurance after deductible is met
Other Practitioner Visits			
Maternity Doctor services (prenatal/postnatal care and delivery) *Preferred Network and In-Network preventive prenatal and postnatal services are covered at 100%.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Retail Health Clinic	$40 copay per visit deductible does not apply	$50 copay per visit deductible does not apply	50% coinsurance after deductible is met
Spinal Manipulation *Coverage is limited to 50 visits per benefit period.*	$40 copay per visit deductible does not apply	$50 copay per visit deductible does not apply	50% coinsurance after deductible is met
Acupuncture	Not covered	Not covered	Not covered
Other Services in an Office			
Allergy Testing	$40 copay per visit deductible does not apply	$50 copay per visit deductible does not apply	50% coinsurance after deductible is met
Prescription Drugs - Dispensed in the office *For the drugs itself dispensed in the office through infusion/injection.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Surgery	$60 copay per surgery deductible does not apply	$90 copay per surgery deductible does not apply	50% coinsurance after deductible is met
Preventive care/screenings/immunizations	No charge	No charge	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
Preventive care for Chronic Conditions *per IRS guidelines*	No charge	No charge	50% coinsurance after deductible is met
Diagnostic Services			
Lab			
Office	30% coinsurance after deductible is met	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Lab/Reference Lab	No charge	No charge	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met	50% coinsurance after deductible is met
X-Ray			
Office	30% coinsurance after deductible is met	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	$40 copay per visit deductible does not apply	$50 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Advanced Diagnostic Imaging - for example: MRI, PET and CAT scans			
Office	30% coinsurance after deductible is met	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	$250 copay per visit deductible does not apply	$300 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	30% 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
Emergency and Urgent Care			
Urgent Care (Office Setting)	$50 copay per visit deductible does not apply	$80 copay per visit deductible does not apply	50% coinsurance after deductible is met
Emergency Room Facility Services *Your copay will be waived if admitted.*	$1,000 copay per visit and 30% coinsurance deductible does not apply	$1,000 copay per visit and 30% coinsurance deductible does not apply	Same as In-Network Tier 1
Emergency Room Doctor and Other Services	30% coinsurance after deductible is met	30% coinsurance after deductible is met	Same as In-Network Tier 1
Emergency Room Doctor Services for Mental Health and Substance Use Disorders	30% coinsurance deductible does not apply	Same as In-Network Tier 1	Same as In-Network Tier 1
Ambulance (Air and Ground) *Authorized Out-of-Network non-emergency ambulance services are limited to an Anthem maximum payment of $50,000 per trip.*	30% coinsurance after deductible is met	30% coinsurance after deductible is met	Same as In-Network Tier 1
Outpatient Mental Health and Substance Use Disorder Services at a Facility			
Facility Fees	No charge deductible does not apply	No charge deductible does not apply	50% coinsurance after deductible is met
Doctor Services	No charge deductible does not apply	No charge deductible does not apply	50% coinsurance after deductible is met
Outpatient Surgery			
Facility Fees			
Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Ambulatory Surgical Center	$300 copay per visit deductible does not apply	$300 copay per visit deductible does not apply	50% coinsurance after deductible is met
Physician and other services including surgeon fees			

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
Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Ambulatory Surgical Center	No charge	No charge	50% coinsurance after deductible is met
Hospital Stay (all Inpatient stays including Maternity, Mental Health and Substance Use Disorder Services)			
Facility fees (for example, room & board) *Coverage for Inpatient Rehabilitation is limited to 120 days per benefit period.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Physician and other services including surgeon fees	30% coinsurance after deductible is met	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Home Health Care	30% coinsurance after deductible is met	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy) *Coverage for physical therapy, occupational therapy and speech therapy is limited to 120 visits combined per benefit period.*			
Office	$40 copay per visit deductible does not apply	$50 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	30% 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) *Coverage for physical therapy, occupational therapy and speech therapy is limited to 120 visits combined per benefit period.*			
Office	$40 copay per visit deductible does not apply	$50 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	30% 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
Pulmonary rehabilitation			
Office	$60 copay per visit deductible does not apply	$90 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Cardiac rehabilitation			
Office	$60 copay per visit deductible does not apply	$90 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Dialysis/Hemodialysis office and outpatient hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Chemo/Radiation Therapy office and outpatient hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (in a facility) *Coverage is limited to 150 days per benefit period. Limit is combined across a skilled nursing facility and an outpatient day rehabilitation program.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met	50% coinsurance after deductible is met
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 *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.*	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	Not applicable	Not applicable	Not applicable
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*** *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 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.* **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.*	$20 copay per prescription (retail) and $50 copay per prescription (home delivery)	$30 copay per prescription (retail only)	50% coinsurance (retail) and Not covered (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.*	$40 copay per prescription (retail) and $100 copay per prescription (home delivery)	$50 copay per prescription (retail only)	50% coinsurance (retail) and Not covered (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.*	$80 copay per prescription (retail) and $200 copay per prescription (home delivery)	$100 copay per prescription (retail only)	50% coinsurance (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	25% coinsurance up to $500 per prescription (retail and home delivery)	35% coinsurance (retail only)	50% coinsurance (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
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	Not covered
Frames *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.*	No charge	Not covered
Single Vision Lenses *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.*	No charge	Not covered
Bifocal Vision Lenses *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.*	No charge	Not covered
Trifocal Vision Lenses *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.*	No charge	Not covered
Elective contact lenses *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.*	No charge	Not covered
Non-Elective Contact Lenses *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.*	No charge	Not covered
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

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
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 2 visits per 12 months.*	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

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 plays 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.

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

NV/SG/Anthem Silver Choice PPO 5000/30%/9200/889B/01-01-2025

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (855) 330-1218

Separate from our language assistance program, we make documents available in alternate 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.

(TTY/TDD: 711)

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (855) 330-1218 .

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (855) 330-1218:

Chinese(中文)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(855) 330-1218。

Farsi (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (855) 330-1218 تماس بگیرید.

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (855) 330-1218.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (855) 330-1218.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (855) 330-1218.

Japanese (日本語):この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。 通訳と話すには、(855) 330-1218 にお電話ください。

Language Access Services:

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(855) 330-1218로 문의하십시오.

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bina'ídiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ąh ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih nínízingo kojį' hodíílnih (855) 330-1218.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer: (855) 330-1218.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (855) 330-1218 ਤੇ ਕਾਲ ਕਰੋ।

Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (855) 330-1218.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (855) 330-1218.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (855) 330-1218.

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (855) 330-1218.

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with 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 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.