The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 844-633-5325 or visit us at [https://www.bswhealthplan.com/Group/Pages/Default.aspx](https://www.bswhealthplan.com/Group/Pages/Default.aspx). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at [HealthCare.gov/sbc-glossary](https://HealthCare.gov/sbc-glossary) or call 844-633-5325 to request a copy.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 844-633-5325 or visit us at [https://www.bswhealthplan.com/Group/Pages/Default.aspx](https://www.bswhealthplan.com/Group/Pages/Default.aspx). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at [HealthCare.gov/sbc-glossary](https://HealthCare.gov/sbc-glossary) or call 844-633-5325 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$1,000 per member / $2,000 per family for a participating provider and $2,000 per member / $4,000 per family for a Non-Participating provider.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive care and Affordable Care Act (ACA) preventive drugs are covered before you meet your deductible.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://HealthCare.gov/coverage/preventive-care-benefits">HealthCare.gov/coverage/preventive-care-benefits</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$3,500 per member / $7,000 per family for a participating provider and $10,500 per member / $21,000 per family for a Non-Participating provider.</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance billing charges, and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out–of–pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="https://www.bswhealthplan.com/Group/Pages/Provider.aspx">https://www.bswhealthplan.com/Group/Pages/Provider.aspx</a> or call 844-633-5325 for a list of network providers.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to</td>
<td>No</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
### Important Questions

#### Why This Matters:

- see a [specialist](#)?

---

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>see a specialist?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

<table>
<thead>
<tr>
<th>Conditions</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Common Medical Event</td>
<td>Participating Provider (You will pay the least)</td>
<td>Non-Participating Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
<td></td>
</tr>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Participating Provider</td>
<td>Non-Participating Provider</td>
</tr>
<tr>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>Adult: No charge for the first non-preventive sick visit in the plan year. $25 copayment per visit for subsequent visits in that plan year, deductible does not apply. Pediatric: No charge per visit, deductible does not apply.</td>
<td>30% coinsurance after deductible.</td>
</tr>
<tr>
<td></td>
<td>$50 copayment per visit, deductible does not apply.</td>
<td>None</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>No charge, deductible does not apply.</td>
<td>30% coinsurance after deductible.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization.</td>
<td>You may have to pay for services that aren’t preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td></td>
<td>Diagnostic test (X-ray, blood work).</td>
<td>No charge, deductible does not apply.</td>
</tr>
<tr>
<td></td>
<td>No charge, deductible does not apply.</td>
<td>30% coinsurance after deductible.</td>
</tr>
<tr>
<td></td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

---

**Important Notes:**

- All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Participating Provider <em>(You will pay the least)</em></th>
<th>Non-Participating Provider <em>(You will pay the most)</em></th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% coinsurance, deductible does not apply</td>
<td>30% coinsurance after deductible</td>
<td>Failure to obtain preauthorization of benefits, other than emergency care, will result in a penalty of the lesser of $500 or 50%.</td>
<td></td>
</tr>
<tr>
<td>Affordable Care Act (ACA) preventive drugs</td>
<td>No charge, deductible does not apply</td>
<td>30% coinsurance after deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 1: Preferred generic drugs</td>
<td>$10 copayment per prescription</td>
<td>30% coinsurance after deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 2: Preferred brand name drugs</td>
<td>$50 copayment per prescription</td>
<td>30% coinsurance after deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 3: Non-preferred generic drugs and non-preferred brand name drugs</td>
<td>$95 copayment per prescription</td>
<td>30% coinsurance after deductible</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**If you need drugs to treat your illness or condition**

More information about prescription drug coverage is available at BSWHealthPlan.com/Group/Pages/Pharmacy

**Copayments** are per 30-day supply. Maintenance drugs are allowed up to a 90-day supply for 2.5 copayments if obtained through a participating pharmacy. Mail Order: Available for a 1- to 90-day supply. Non-maintenance drugs obtained through mail order are limited to a 30-day supply maximum. Specialty drugs limited to a 30-day supply. Formulary insulin prescriptions have a maximum copayment of $25 per prescription per 30-day supply. If a brand name drug is requested when a generic equivalent is available, the member is responsible for the non-preferred copayment plus the difference in cost of the brand name drug and generic equivalent drug.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Participating Provider (You will pay the least)</th>
<th>Non-Participating Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specialty drugs</strong></td>
<td></td>
<td>Tier 1: $250 copayment per prescription</td>
<td>30% coinsurance after deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tier 2: $250 copayment per prescription</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tier 3: 20% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% coinsurance after deductible</td>
<td>30% coinsurance after deductible</td>
<td>Failure to obtain preauthorization of benefits, other than emergency care, will result in a penalty of the lesser of $500 or 50%.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance after deductible</td>
<td>30% coinsurance after deductible</td>
<td></td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care</td>
<td>$500 copayment per visit, plus 10% coinsurance, deductible does not apply</td>
<td>$500 copayment per visit, plus 10% coinsurance, deductible does not apply</td>
<td>Emergency room copayment waived if episode results in hospitalization for the same condition within 24 hours.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$500 copayment per service, plus 10% coinsurance, deductible does not apply</td>
<td>$500 copayment per service, plus 10% coinsurance, deductible does not apply</td>
<td>None</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Participating Provider (You will pay the least)</td>
<td>Non-Participating Provider (You will pay the most)</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
<td>------------------------------------</td>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Urgent care</td>
<td>$50 copayment per visit, deductible does not apply</td>
<td>$50 copayment per visit, deductible does not apply</td>
<td>Failure to obtain preauthorization of benefits, other than emergency care, will result in a penalty of the lesser of $500 or 50%.</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% coinsurance after deductible</td>
<td>30% coinsurance after deductible</td>
<td>Failure to obtain preauthorization of benefits, other than emergency care, will result in a penalty of the lesser of $500 or 50%.</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance after deductible</td>
<td>30% coinsurance after deductible</td>
<td></td>
</tr>
</tbody>
</table>
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                | Adult: $25 copayment per visit, 10% coinsurance after deductible for all other outpatient services  
Pediatric: No charge per visit, deductible does not apply | 30% coinsurance after deductible                     | Failure to obtain preauthorization of partial hospitalization benefits, other than emergency care, will result in a penalty of the lesser of $500 or 50%. |
<p>| If you need mental health, behavioral health, or substance abuse services | Inpatient services                 | 10% coinsurance after deductible               | 30% coinsurance after deductible                     | |
| If you are pregnant                                      | Office visits                       | $25 copayment per visit, deductible does not apply | 30% coinsurance after deductible                     | Cost sharing does not apply for preventive care. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |</p>
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Participating Provider (You will pay the least)</th>
<th>Non-Participating Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childbirth/delivery professional services</td>
<td>10% coinsurance after deductible</td>
<td>30% coinsurance after deductible</td>
<td>Inpatient care for the mother and newborn child in a health care facility is covered for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarean section.</td>
<td></td>
</tr>
<tr>
<td>Childbirth/delivery facility services</td>
<td>10% coinsurance after deductible</td>
<td>30% coinsurance after deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>10% coinsurance after deductible</td>
<td>30% coinsurance after deductible</td>
<td>Limited to 60 visits per plan year. Failure to obtain preauthorization of benefits, other than emergency care, will result in a penalty of the lesser of $500 or 50%.</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>$25 copayment per visit, deductible does not apply</td>
<td>30% coinsurance after deductible</td>
<td>Limited to 35 visits for rehabilitation services and 35 visits for habilitation services per plan year. The limit is combined for physical therapy, occupational therapy, and speech therapy. Limits do not apply for therapies for children with developmental delays, autism spectrum disorder and mental health services. Failure to obtain preauthorization of benefits, other than emergency care, will result in a penalty of the lesser of $500 or 50%.</td>
<td></td>
</tr>
<tr>
<td>Habilitation services</td>
<td>$25 copayment per visit, deductible does not apply</td>
<td>30% coinsurance after deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>10% coinsurance after deductible</td>
<td>30% coinsurance after deductible</td>
<td>Limited to 25 days per plan year. Failure to obtain preauthorization of benefits, other than emergency care, will result in a penalty of the lesser of $500 or 50%.</td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Participating Provider (You will pay the least)</td>
<td>Non-Participating Provider (You will pay the most)</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-----------------------------------------------</td>
<td>---------------------------------------------------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>10% coinsurance after deductible</td>
<td>30% coinsurance after deductible</td>
<td>Failure to obtain preauthorization of benefits, other than emergency care, will result in a penalty of the lesser of $500 or 50%.</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No charge, deductible does not apply</td>
<td>30% coinsurance after deductible</td>
<td></td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td>Children’s eye exam</td>
<td>Not covered</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>None</td>
</tr>
</tbody>
</table>
Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acupuncture</td>
</tr>
<tr>
<td>• Bariatric surgery</td>
</tr>
<tr>
<td>• Cosmetic surgery</td>
</tr>
<tr>
<td>• Dental care (Adult and Child)</td>
</tr>
<tr>
<td>• Infertility treatment</td>
</tr>
<tr>
<td>• Long-term care</td>
</tr>
<tr>
<td>• Non-emergency care when traveling outside the U.S.</td>
</tr>
<tr>
<td>• Routine eye care (Adult and Child)</td>
</tr>
<tr>
<td>• Routine foot care</td>
</tr>
<tr>
<td>• Weight loss programs</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Services (Limitations apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Chiropractic care (Limited to 35 visits per plan year)</td>
</tr>
<tr>
<td>• Hearing aids (Limited to one device per ear every 3 years for members through the age of 18)</td>
</tr>
<tr>
<td>• Private duty nursing (when medically necessary and preauthorized. Limitations apply when used under Home Health Care)</td>
</tr>
</tbody>
</table>

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is Baylor Scott & White Care Plan at 844-633-5325 or BSWHealthPlan.com; Department of Labor’s Employee Benefits Security Administration at 866-444-EBSA (3272) or DOL.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit HealthCare.gov or call 800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Baylor Scott & White Care Plan at 844-633-5325 or BSWHealthPlan.com; Department of Labor’s Employee Benefits Security Administration at 866-444-EBSA (3272) or DOL.gov/ebsa/healthreform; Texas Department of Insurance at 800-578-4677 or TDI.texas.gov.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

To see examples of how this plan might cover costs for a sample medical situation, see the next section.
About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)</th>
<th>Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia's Simple Fracture (in-network emergency room visit and followup care)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan’s overall deductible $1,000</td>
<td>The plan’s overall deductible $1,000</td>
<td>The plan’s overall deductible $1,000</td>
</tr>
<tr>
<td>Specialist copayment $50</td>
<td>Specialist copayment $50</td>
<td>Specialist copayment $50</td>
</tr>
<tr>
<td>Hospital (facility) coinsurance 10%</td>
<td>Hospital (facility) coinsurance 10%</td>
<td>Hospital (facility) coinsurance 10%</td>
</tr>
<tr>
<td>Other coinsurance 10%</td>
<td>Other coinsurance 10%</td>
<td>Other coinsurance 10%</td>
</tr>
</tbody>
</table>

This EXAMPLE event includes services like:

- Specialist office visits (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (ultrasounds and blood work)
- Specialist visit (anesthesia)

Total Example Cost $12,700

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$10</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

What isn’t covered

Limits or exclusions $60

The total Peg would pay is $2,070

This EXAMPLE event includes services like:

- Primary care physician office visits (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs
- Durable medical equipment (glucose meter)

Total Example Cost $5,600

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$800</td>
</tr>
<tr>
<td>Copayments</td>
<td>$700</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

What isn’t covered

Limits or exclusions $20

The total Joe would pay is $1,520

This EXAMPLE event includes services like:

- Emergency room care (including medical supplies)
- Diagnostic test (X-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

Total Example Cost $2,800

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$900</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$10</td>
</tr>
</tbody>
</table>

What isn’t covered

Limits or exclusions $20

The total Mia would pay is $1,910

The plan would be responsible for the other costs of these EXAMPLE covered services.
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-844-633-5325 (TTY: 711).

Baylor Scott & White Care Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Baylor Scott & White Care Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Baylor Scott & White Care Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Written information in other formats (large print and accessible electronic formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Baylor Scott & White Care Plan Compliance Officer at 1-214-820-8888 or send an email to HPCompliance@BSWHealth.org.

If you believe that Baylor Scott & White Care Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Baylor Scott & White Care Plan, Compliance Officer
1206 West Campus Drive, Suite 151
Temple, Texas 76502

Compliance HelpLine; 1-888-484-6977 or https://app.mycompliancereport.com/report?cid=swhp

You can file a grievance in person or by mail, online, or email. If you need help filing a grievance, the Compliance Officer is available to help you.

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, 1-800-537-7697 (TDD)

Complaint forms are available at https://www.hhs.gov/civil-rights/filing-a-complaint/index.html.
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-844-633-5325 (TTY: 711).

Spanish:
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-633-5325 (TTY: 711).

Vietnamese:

Chinese:
注意：如果使用繁體中文，可以免費獲得語言援助服務。請致電 1-844-633-5325 (TTY：711)。

Korean:

Arabic:
)رﻗﻢ 844-633-5325-1.ﻣﻠﺤﻮظﺔ: إذا كنت تتحدث أذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-633-5325 (رقم

Urdu:
خشنا: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی خدمات مفت دستیاب بیں کل

Tagalog:

French:

Hindi:
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-844-633-5325 (TTY: 711) पर कॉल करें।

Persian:
فرام مایاد. با (711) 1-844-633-5325-1 نماس گویی ویکریز جنگ، توجه: اگر به زبان فارسی گفتگو می کنید، تمایلات زبانی بصورت رایگان برای شما

German:

Gujarati:
સૂચના: ત્યારે તમે ગુજરાતી બોલતા હો રહ્યા હોતા, તો તમારી ભાષા સહાયક સેવાએનું ઉપલબ્ધ થશે. તમારી ફોન નંબર 1-844-633-5325 (TTY: 711).

Russian:
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-633-5325 (телефон: 711).

Japanese:
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-844-633-5325 (TTY:711) まで、お電話にてご連絡ください。

Laotian:
ປປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-844-633-5325 (TTY:711).

BSWCP_LanguageAssistance09/2021_C