



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, visit

<https://ambettermeridian.com/2024-brochures.html>, or call 1-833-993-2426 (TTY Relay 711). 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 <https://www.healthcare.gov/sbc-glossary> or call 1-833-993-2426 (TTY Relay 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$1,500 individual / \$3,000 family.	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> services, primary care, <a href="#">specialist</a> , and <a href="#">urgent care</a> office visits, children's eye exam and glasses, lab-work, generic and preferred brand drugs are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network providers</a> : \$8,700 individual / \$17,400 family. Not applicable for <a href="#">out-of-network providers</a> .	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, penalties for failure to obtain <a href="#">preauthorization</a> for services, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="https://ambettermeridian.com/findadoc">https://ambettermeridian.com/findadoc</a> or call 1-833-993-2426 (TTY Relay 711) for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$30 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply	Not covered	Covered No Limit.
	<a href="#">Specialist</a> visit	\$60 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply	Not covered	Covered No Limit.
	<a href="#">Preventive care/screening/immunization</a>	No charge; <a href="#">deductible</a> does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	25% <a href="#">Coinsurance</a> for laboratory & professional services  25% <a href="#">Coinsurance</a> for x-ray & diagnostic imaging  25% <a href="#">Coinsurance</a> for laboratory & professional services and x-ray & diagnostic imaging at other places of service	Not covered	Prior authorization may be required. Covered No Limit. Other places of service may include: Hospital, Emergency Room, or Outpatient Facility.  Failure to obtain prior authorization for any service that requires prior authorization will result in a denial of benefits.
	Imaging (CT/PET scans, MRIs)	25% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. Covered No Limit.
If you need drugs to treat your illness or condition	Generic drugs (Tier 1)	Preferred Generic Retail: \$15 <a href="#">Copay</a> / prescription; <a href="#">deductible</a> does not apply  Generic Retail: \$15 <a href="#">Copay</a> / prescription; <a href="#">deductible</a> does not apply	Not covered	Prior authorization may be required. <a href="#">Prescription drugs</a> are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail <a href="#">cost-sharing</a> amount.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
More information about <a href="https://ambettermeridian.com/2024formulary">prescription drug coverage</a> is available at <a href="https://ambettermeridian.com/2024formulary">https://ambettermeridian.com/2024formulary</a> .	Preferred brand drugs (Tier 2)	Retail: \$30 <a href="#">Copay</a> / prescription; <a href="#">deductible</a> does not apply	Not covered	Prior authorization may be required. <a href="#">Prescription drugs</a> are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail <a href="#">cost-sharing</a> amount.
	Non-preferred brand and non-preferred generic drugs (Tier 3)	Retail: \$60 <a href="#">Copay</a> / prescription; <a href="#">deductible</a> does not apply	Not covered	
	<a href="#">Specialty drugs</a> (Tier 4)	Retail: \$250 <a href="#">Copay</a> / prescription; <a href="#">deductible</a> does not apply	Not covered	Prior authorization may be required. <a href="#">Prescription drugs</a> are provided up to 30 days retail and up to 30 days through mail order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	25% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. Covered No Limit.
If you need immediate medical attention	<a href="#">Emergency room care</a>	25% <a href="#">Coinsurance</a>	25% <a href="#">Coinsurance</a>	Covered No Limit.
	<a href="#">Emergency medical transportation</a>	25% <a href="#">Coinsurance</a>	25% <a href="#">Coinsurance</a>	Covered No Limit. Note: Prior authorization is not required for emergency transport, however, all non-emergent transport requires prior authorization. If you receive service from an out of <a href="#">network</a> ground/water ambulance <a href="#">provider</a> , you may be subject to <a href="#">balance billing</a> .
	<a href="#">Urgent care</a>	\$45 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply	Not covered	Covered No Limit.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	25% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. Covered No Limit.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: \$30 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply; Other Outpatient Services: 25% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. Covered No Limit. ( <a href="#">Primary Care Provider</a> (PCP) and other practitioner office visits do not require prior authorization.)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Inpatient services	25% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. Covered No Limit.
If you are pregnant	Office visits	\$30 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply	Not covered	Prior authorization not required for deliveries within the standard timeframe per federal regulation, but may be required for other services. <a href="#">Cost-sharing</a> does not apply for <a href="#">preventive services</a> , such as routine pre-natal and post-natal <a href="#">screenings</a> . Depending on the type of services, <a href="#">coinsurance</a> , <a href="#">deductible</a> or <a href="#">copayment</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	25% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. <a href="#">Cost-sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery facility services	25% <a href="#">Coinsurance</a>	Not covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	25% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. Covered No Limit.
	<a href="#">Rehabilitation services</a>	Outpatient: \$30 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply Inpatient: 25% <a href="#">Coinsurance</a>	Not covered	Outpatient: Prior authorization may be required. Outpatient rehabilitation is limited to the following: 30 combined visits per year for physical therapy and occupational therapy (combined with chiropractic care), 30 visits per year for speech therapy and 30 visits per year for pulmonary therapy. Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis. Inpatient: Prior authorization may be required. Covered No Limit.
	<a href="#">Habilitation services</a>	Outpatient: \$30 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply	Not covered	Outpatient: Prior authorization may be required. Habilitation outpatient services are limited to the following: 30 combined visits

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		Inpatient: 25% <a href="#">Coinsurance</a>		per year for physical therapy and occupational therapy (combined with chiropractic care), 30 visits per year for speech therapy, and 30 visits per year for pulmonary therapy. Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis. Inpatient: Prior authorization may be required. Covered No Limit.
	<a href="#">Skilled nursing care</a>	25% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. Limited to 45 days per year.
	<a href="#">Durable medical equipment</a>	25% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. Covered No Limit.
	<a href="#">Hospice services</a>	25% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. Covered No Limit.
If your child needs dental or eye care	Children's eye exam	No charge; <a href="#">deductible</a> does not apply	Not covered	Limited to 1 visit per year.
	Children's glasses	No charge; <a href="#">deductible</a> does not apply	Not covered	Limited to 1 item per year.
	Children's dental check-up	Not covered	Not covered	None

#### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)			
<ul style="list-style-type: none"> <li>Abortion (Except in cases when the life of the mother is endangered)</li> <li>Acupuncture</li> <li>Cosmetic surgery</li> </ul>	<ul style="list-style-type: none"> <li>Dental (Children)</li> <li>Hearing aids</li> <li>Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S.</li> <li>Private-duty nursing</li> </ul>	

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

- |   |   |   |
|---|---|---|
| • Bariatric surgery (Limited to 1 surgery per lifetime.)  | • Infertility treatment (Limited to services for diagnostic tests to find the cause of infertility) | • Routine foot care   |
| • Chiropractic care (Limited to 30 combined visits per year (combined for occupational therapy, physical therapy and chiropractic care).) | • Routine eye care (Adult-one visit & one item per year. Dollar allowance applies to hardware.)     | • Weight loss programs (Weight loss programs under the supervision of a physician & obesity counseling) |
| • Dental care (Adult-visit & item limits apply per year. \$1,000 annual dollar limit per year per person.)                                |   |   |

**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: Ambetter from Meridian at 1-833-993-2426 (TTY Relay 711); Department of Insurance and Financial Services, 530 W. Allegan Street, 7th Floor, Lansing, MI 48933, Phone No. 1-877-999-6442; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272); Michigan Health Options at 1-877-527-9431; Office of Personnel Management Multi State [Plan](#) Program at <https://www.opm.gov/healthcare-insurance/multi-state-plan-program/external-review/>. 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 [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**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: Department of Insurance and Financial Services, 530 W. Allegan Street, 7th Floor, Lansing, MI 48933, Phone No. 1-877-999-6442

**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 Minimum Value Standards? Not Applicable.**

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:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-833-993-2426 (TTY Relay 711).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-993-2426 (TTY Relay 711).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-833-993-2426 (TTY Relay 711).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-833-993-2426 (TTY Relay 711).

*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.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,500
■ <a href="#">Specialist copayment</a>	\$60
■ Hospital (facility) <a href="#">coinsurance</a>	25%
■ Other <a href="#">coinsurance</a>	25%

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
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$40
<a href="#">Coinsurance</a>	\$2,100
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,700

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,500
■ <a href="#">Specialist copayment</a>	\$60
■ Hospital (facility) <a href="#">coinsurance</a>	25%
■ Other <a href="#">coinsurance</a>	25%

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
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$900
<a href="#">Copayments</a>	\$900
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,820

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,500
■ <a href="#">Specialist copayment</a>	\$60
■ Hospital (facility) <a href="#">coinsurance</a>	25%
■ Other <a href="#">coinsurance</a>	25%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic tests](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$100
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900





<b>Italian:</b>	Se Lei o una persona a cui sta fornendo assistenza ha domande su Ambetter from Meridian e non ha una perfetta padronanza della lingua inglese, ha il diritto di ricevere aiuto e informazioni nella Sua lingua gratuitamente e tempestivamente. Se Lei o una persona a cui sta fornendo assistenza presenta una condizione uditiva e/o visiva che impedisce la comunicazione, ha il diritto di ricevere servizi ausiliari gratuitamente e tempestivamente. Per ricevere una traduzione o un servizio ausiliario, contatti i Servizi per i membri al numero 1-833-993-2426 (TTY Relay 711).
<b>Japanese:</b>	ご自身やあなたが介護している他の人が、Ambetter from Meridianについてご質問をお持ちの場合、英語に自信がなくても無料かつタイムリーにご希望の言語でヘルプや情報を得ることができます。ご自身や、あなたが介護している他の人の聴覚や視覚の状態のためやり取りが難しい場合でも、無料かつタイムリーに補助サービスを受けることができます。翻訳や補助サービスを受けるには、1-833-993-2426 (TTY Relay 711)のメンバーサービスにご連絡ください。
<b>Russian:</b>	Если у вас или у лица, которому вы помогаете, возникли какие-либо вопросы о программе страхования Ambetter from Meridian, при этом вы недостаточно хорошо владеете английским языком, вы имеете право на бесплатную и своевременную помощь и информацию на своем родном языке. Если у вас или у лица, которому вы помогаете, наблюдается какое-либо нарушение слуха и/или зрения, которое препятствует коммуникации, вы имеете право на бесплатные и своевременные вспомогательные услуги и помощь. Для получения услуг перевода или вспомогательных услуг обратитесь в отдел обслуживания участников программы страхования по номеру 1-833-993-2426 (TTY Relay 711).
<b>Serbo-Croatian:</b>	Ako Vi, ili neko kome pomažete, imate pitanja u vezi sa Ambetter from Meridian, a ne govorite engleski jezik, imate pravo na besplatnu i blagovremenu pomoć i informacije na sopstvenom jeziku. Ako Vi, ili neko kome pomažete, imate neki poremećaj sluha i/ili vida zbog kojeg je onemogućena komunikacija, imate pravo da besplatno i blagovremeno dobijete pomagala i pomoćne usluge. Obratite se odeljenju za pružanje usluga članovima pozivom na broj 1-833-993-2426 (TTY Relay 711) da biste dobili usluge prevoda ili pomoćne usluge.
<b>Tagalog:</b>	Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Ambetter from Meridian, at hindi ka mahusay sa Ingles, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos at sa maagap na paraan. Kung ikaw, o ang iyong tinutulungan, ay may kondisyon sa pandinig at/o paningin na nakakaapekto sa komunikasyon, may karapatan kang makatanggap ng mga karagdagang tulong at serbisyo nang walang gastos at sa maagap na paraan. Para makatanggap ng mga serbisyo sa pagsasalin o mga karagdagang serbisyo, mangyaring makipag-ugnayan sa Mga Serbisyo para sa Miyembro sa 1-833-993-2426 (TTY Relay 711).

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### Statement of Non-Discrimination

Ambetter from Meridian is underwritten by Meridian Health Plan of Michigan, Inc., which is a Qualified Health Plan issuer in the Michigan Health Insurance Marketplace. Meridian Health Plan of Michigan, Inc., complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including pregnancy, sexual orientation, gender identity, or sex characteristics). This is a solicitation for insurance. © 2023 Meridian Health Plan of Michigan, Inc. All rights reserved. [AmbetterMeridian.com](https://www.AmbetterMeridian.com)

If you, or someone you are helping, have questions about Ambetter of Meridian, and are not proficient in English, you have the right to get help and information in your language at no cost and in a timely manner. If you, or someone you are helping, have an auditory and/or visual condition that impedes communication, you have the right to receive auxiliary aids and services at no cost and in a timely manner. To receive translation or auxiliary services, please contact Member Services at 1-833-993-2426 (TTY Relay 711). If you believe that Meridian Health Plan of Michigan, Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including pregnancy, sexual orientation, gender identity, or sex characteristics), please contact Member Services at 1-833-993-2426 (TTY Relay 711). You may also submit a grievance by phone to 1-833-993-2426 (TTY Relay 711). For information on filing a discrimination complaint directly with the U.S. Department of Health and Human Services, Office of Civil Rights, please visit <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>.

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