

# 2026 Individual Dental Plans

Helping you with a healthy smile

Policy Form Numbers:  
3-073P (01/26)  
3-074P (01/26)  
3-075P (01/26)  
18-080 (01/26)  
18-1019P (01/26)  
18-1071 (01/26)  
18-2249 (01/26)  
18-2284 (01/26)

## The Dental Coverage You Deserve

At Blue Cross of Idaho, it's our mission to provide quality dental plans, so you can get the healthy smile you deserve. We offer a broad range of dental choices to meet your unique needs.

- » Preventive care services such as cleanings and exams
- » Plans offering orthodontic treatment
- » Pediatric plans with no waiting periods for those under age 19
- » Copay plans with clear costs, with set prices for each service
- » Robust dental provider network in Idaho and nationally through the Dental GRID network
- » Local, live customer service

## Need help choosing a plan?

We know choosing an insurance plan can be a complicated process, which is why we offer no-cost options for helpful advice.

### FROM AN AGENT

Get advice at no cost from a local, certified and independent insurance agent near you with [bcidaho.com/findabroker](http://bcidaho.com/findabroker).

### WITH A LOCAL DIRECT SALES REPRESENTATIVE

Call us at **888-GO-CROSS (888-462-7677)**.

### TERMS TO KNOW:

**DEDUCTIBLE:** The set amount you're responsible for before your plan begins to pay benefits, when applicable.

**COINSURANCE:** Once your deductible is satisfied, you and your plan share the cost of coverage. The percentages you and your plan are responsible for are outlined in your plan details.

**COPAYMENT:** A set amount you pay directly to the dental provider for a service performed.

**MAXIMUM ALLOWANCE:** The highest amount payable for covered services.

**BENEFIT PERIOD:** The 12-month period to which your deductibles, maximums, and other plan provisions are applied.

**BENEFIT PERIOD MAXIMUM:** The amount your plan will pay for dental covered services during the benefit period.

**IN-NETWORK PROVIDER:** Dentists and other licensed dental care providers that contract with Blue Cross of Idaho to provide dental services under your dental plan for a more affordable price.




# Compare Out-of-Pocket Costs

## ORTHODONTIA NEEDS

The Smiths have a child who needs braces next year. Here are some options.

Plan Options	Dental Blue Connect	Dental Choice Core	Dental Choice	Dental Choice Plus
Waiting Period	12 Months		n/a	
Out-of-pocket Cost	\$2,800		\$450*	

\*For medically necessary non-cosmetic services and only covered under age 19.




The Smith family likes **CLARITY**

## SAVING ON COSTS

Shannon, age 40, has had a few issues with her teeth recently and is concerned about the cost to take care of her teeth.

Plan Options	Healthy Smiles Preferred	Healthy Smiles Copay	Dental Choice Plus	Dental Blue Connect Individual
Premium	\$	\$\$	\$\$\$	\$\$\$\$
<b>Cavity Filling</b> Benefits based on provider billing \$250	\$90 (\$50 deductible + \$40 coinsurance)	\$125 (\$50 deductible + \$75 copay)	\$98 (\$60 deductible + \$38 coinsurance)	\$95 (\$25 office visit copay + \$70 copay)
<b>Crown</b> Benefits based on provider billing \$1,000	\$525 (\$50 deductible + \$475 coinsurance)	\$550 (\$50 deductible + \$500 copay)	\$530 (\$60 deductible + \$470 coinsurance)	\$535 (\$35 office visit copay + \$500 copay)




Shannon likes **AFFORDABILITY**

## PRIMARILY PREVENTIVE CARE

Tom and Alice have healthy teeth and want to keep it that way. Preventive services such as cleanings and X-rays are most important to them.

Plan Options	Healthy Smiles Preventive	Healthy Smiles Copay	Dental Choice Plus	Dental Blue Connect Individual
Out-of-pocket Cost	\$20 copay	\$30 copay	\$0	\$25 copay*

\*This is the office visit copay, there is no additional copay for preventive services



Tom and Alice like **PROTECTION**

Questions to ask when choosing a plan:	Plans to consider:
<i>Are you looking for just preventive coverage?</i>	Healthy Smiles Preventive
<i>Do you expect higher dental expenses this year?</i>	Dental Blue Connect Individual or Healthy Smiles Copay
<i>Do you or does anyone in your family need braces?</i>	Dental Blue Connect Individual
<i>Do you have children under the age of 19 that need extensive dental work?</i>	Dental Choice or Dental Choice Plus
<i>Is it important to you to know your costs up front?</i>	Healthy Smiles Copay or Dental Blue Connect Individual
<i>Do you enjoy being rewarded for using your dental benefits?</i>	Healthy Smiles Preferred

# Healthy Smiles

Dental plans designed to meet your unique needs. A variety of choices to support your overall health, financial and dental needs.



## HEALTHY SMILES PREVENTIVE



Healthy Smiles Preventive covers **preventive dental services** with no benefit period maximum, no in-network deductibles and no waiting periods. Because Blue Cross of Idaho covers 100% of in-network preventive services after a \$20 copayment, this is the best option if you're looking for a low-premium dental plan.

## HEALTHY SMILES PLUS



Healthy Smiles Plus is an affordable option that provides the same coverage as Healthy Smiles Preventive, **plus basic dental services** such as scaling and root planing, fillings, and four periodontal maintenance visits per benefit period.

## HEALTHY SMILES PREFERRED



Healthy Smiles Preferred is a great comprehensive plan for you and your family. This plan provides coverage for **preventive, basic and major dental services**, including the opportunity to carry over up to \$250 of unused dental benefit dollars from one year to the next (dental maximum carryover).

## HEALTHY SMILES COPAY



Healthy Smiles Copay is a plan that offers **set copays for each service**. Comprehensive benefits include preventive, basic and major services, plus coverage for nitrous oxide. No waiting periods or annual benefit maximum when your plan renews after your first year. Operates on the Dental Preferred Provider Organization network (DPPO).

## HEALTHY SMILES ELITE



Healthy Smiles Elite is a plan that offers a **high benefit maximum**. This plan also rewards you for your loyalty by lowering your coinsurance for major services, as long as you see your dentist at least once during the year for a preventive checkup.

		Healthy Smiles Preventive	Healthy Smiles Plus	Healthy Smiles Preferred	Healthy Smiles Elite	Healthy Smiles Copay
BENEFIT DETAILS		In-network	In-network	In-network	In-network	In-network
	<b>Deductible</b>	Not Applicable	\$50 per person per benefit period, three-person family maximum	\$50 per person per benefit period, three-person family maximum	\$45 per person per benefit period, three-person family maximum	\$50 per person per benefit period
	<b>Benefit Period Maximum</b>	Not Applicable	\$1,000 per person per benefit period	\$1,000 per person per benefit period	\$2,500 per person per benefit period	\$1,500 yr 1, no max year 2+
PREVENTIVE	<b>Preventive Dental Services</b> Oral exams, cleanings, X-rays, fluoride for eligible dependent children	Member pays nothing after \$20 copayment per visit	Member pays nothing after \$20 copayment per visit	Member pays nothing after \$20 copayment per visit	Member pays nothing after \$25 copayment per visit	\$30 copay
						Sealants \$30 copay
BASIC	<b>Basic Dental Services</b> (fillings, extractions); six-month waiting period applies	Not Covered	Member pays 20% of maximum allowance after deductible	Member pays 20% of maximum allowance after deductible	Member pays 20% of maximum allowance after deductible	<b>Fillings</b> \$75 copay
						<b>Periodontal Maintenance</b> \$75 copay
						<b>Extraction</b> \$150 copay
						<b>Nitrous Oxide</b> \$45 copay
MAJOR	<b>Major Dental Services</b>	Not Covered	Not Covered	Member pays 50% of maximum allowance after deductible	<b>Year 1:</b> Member pays 80%* of maximum allowance after deductible  <b>Year 2:</b> Member pays 40% of maximum allowance after deductible  <b>Year 3:</b> Member pays 30% of maximum allowance after deductible	<b>Crowns</b> \$500 copay
						<b>Bridges</b> \$500 copay**
						<b>Implants</b> \$1,250 copay**
						<b>Dentures</b> \$500 copay**
	<b>Orthodontic Services</b>	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
	<b>Dental Rewards Program</b>	Not Applicable	Not Applicable	\$250 per person per benefit period (up to a maximum of \$1,000, per insured)	Not Applicable	Not Applicable

\* Please contact Customer Service at 208-363-8755 or 800-289-7929 for an Insured's specific level of coverage.

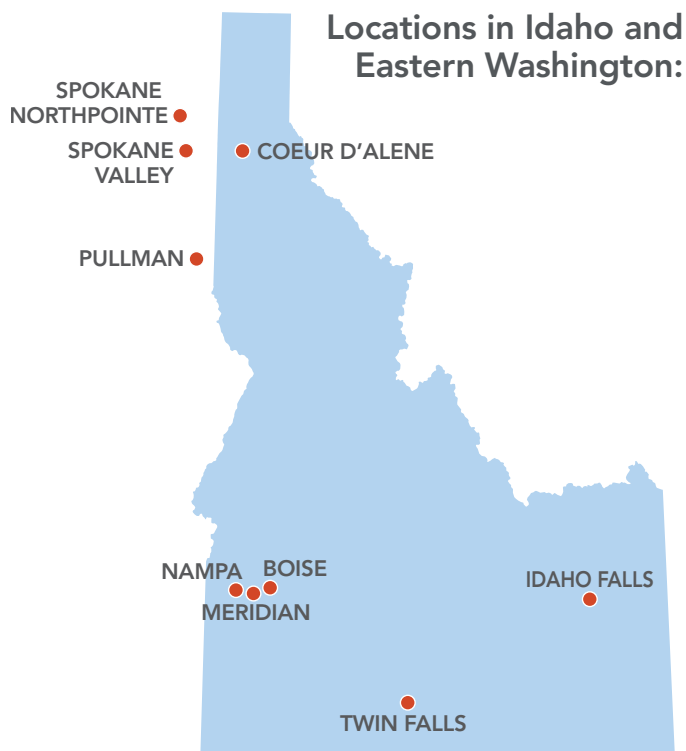
\*\* Only one prosthetic appliance covered per benefit period; bridges, dentures and implants.

# Dental Blue Connect Individual

## Coverage with Willamette Dental

Blue Cross of Idaho is pleased to offer you Dental Blue Connect Individual in partnership with Willamette Dental. This is an individual dental insurance plan that will provide coverage for all your dental care needs. There is no maximum amount of dental services that this plan will cover and there are no deductibles that need to be met. Your coverage gives you simple access to dental care.

To receive benefits, schedule your care at a Willamette Dental office by calling 855-433-6825. When visiting the dental office or calling in for an appointment, identify yourself as a Dental Blue Connect Individual member. To find a Willamette Dental office location, visit [bcidaho.com/wddentist](http://bcidaho.com/wddentist).



## Benefit Summary for Services by a Participating Dentist

COVERED SERVICES	MEMBER BENEFITS
Annual Maximum	Does not apply
Deductible	Does not apply
General Office Visit	\$25 copay
Specialist Office Visit	\$35 copay
Dental Exams and X-rays	\$0 copay
Teeth Cleaning	\$0 copay
Fluoride Treatment	\$15 copay
Sealants (per Tooth)	\$15 copay
Filling - Amalgam	\$45 copay
Filling - Resin (Anterior)	\$70 copay
Filling - Resin (Posterior)	\$80 copay
Stainless Steel Crown	\$90 copay
Porcelain/Metal Crown	\$500 copay <sup>1</sup>
Complete Upper or Lower Denture	\$600 copay <sup>1</sup>
Bridge (per Tooth)	\$500 copay <sup>1</sup>
Root Canal Therapy - Anterior Tooth / Bicuspid Tooth / Molar	\$225 / \$325 / \$425 copays
Osseous Surgery (per Quadrant)	\$325 copay
Root Planing (per Quadrant)	\$100 copay
Routine Extraction (per Tooth)	\$50 copay
Surgical Extraction (per Tooth)	\$190 copay
Pre-Orthodontic Services	\$150 copay <sup>1, 2</sup>
Comprehensive Orthodontia	\$2,800 copay <sup>1</sup>
Nitrous Oxide (per Visit)	\$50 copay

Out-of-area emergency treatment by an out-of-network provider is reimbursed up to \$100 per visit. This plan covers the first \$10 per visit for non-emergency treatment by out-of-network providers without a referral, subject to the exclusions.

<sup>1</sup> Benefit available after a 12-month waiting period.

<sup>2</sup> Applies towards comprehensive orthodontia copayment if patient accepts treatment plan.

This is a summary of common procedures covered in the Dental Blue Connect Individual plan. The contract will control. Please refer to the contract for a complete description of benefits, limitations, and exclusions.

# Orthodontic Treatment for the Entire Family

## Getting Started

As part of your Dental Blue Connect Individual plan, your family also has access to affordable orthodontic care<sup>1</sup>, after a 12-month waiting period.

You must receive an initial evaluation from a Willamette Dental general dentist to see if you are a candidate for orthodontic treatment. The Willamette Dental general dentist will provide a referral for a pre-orthodontic consultation with a Willamette Dental orthodontist if you are eligible. A consultation includes an initial exam, X-rays, study models and an oral evaluation for \$150. For more information or to schedule an appointment call 855-433-6825. Select 2 for member services.

<sup>1</sup> Invisalign treatment has additional charges.

### Pre-Orthodontia Consultation Fees

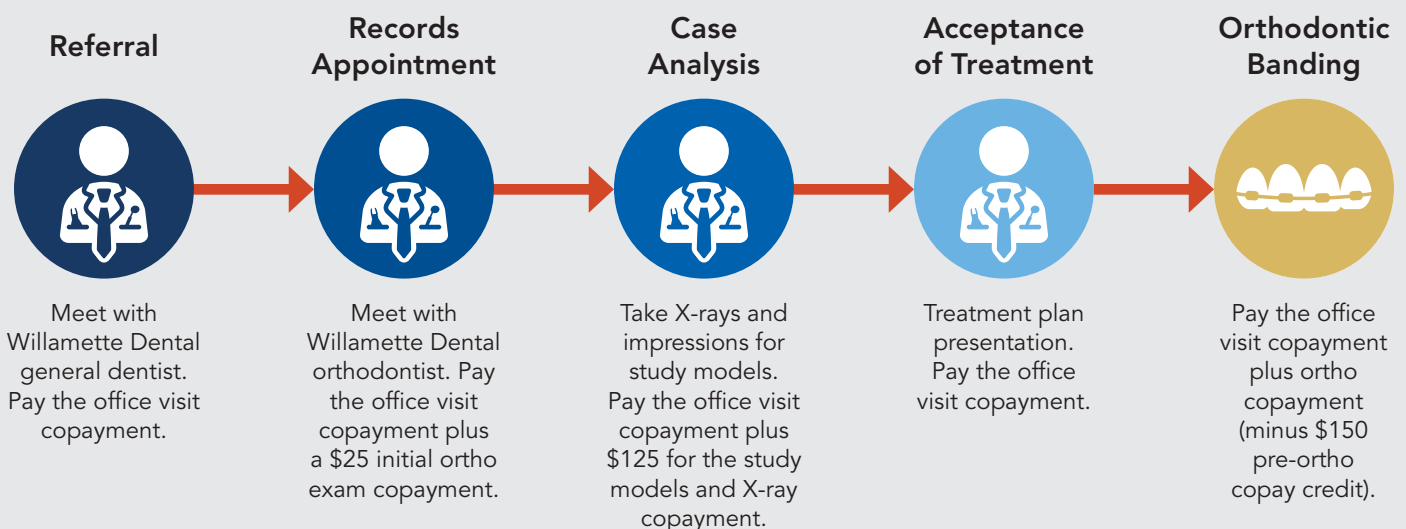
Initial Orthodontic Exam:	\$25
Study Models and X-rays:	\$125
Case Presentation:	\$0

These non-refundable, pre-orthodontia consultation fees are credited toward the total cost of treatment if you proceed with treatment.

### Orthodontic Copayment

The copayment for orthodontia is \$2,800. At the time of banding, a \$1,500 payment is required. The remaining balance may be spread over payments during the next 12 months.

## PRE-ORTHODONTIA APPOINTMENT PROCESS



Willamette Dental is an independent company that contracts with Blue Cross of Idaho to offer services that connect qualified members to dental programs. This is not a Blue Cross of Idaho product. Willamette Dental is solely responsible for its products and services. Blue Cross of Idaho is not responsible for the provision of, or failure to provide, any products and services offered by Willamette Dental.

## Qualified Dental Plans

Blue Cross of Idaho is excited to bring Dental Choice Core, a new ACA Qualified Dental plan, to market. This plan supports adults looking for mostly preventive services at a low cost, while still providing comprehensive coverage for children under age 19. All of our Qualified Dental Plans meet ACA requirements and can be purchased at [bcidaho.com](http://bcidaho.com) or [yourhealthidaho.org](http://yourhealthidaho.org).

Under Age 19	Dental Choice Core (Under the age of 19)	Dental Choice (Under the age of 19)	Dental Choice Plus (Under the age of 19)
BENEFIT DETAILS	In-network	In-network	In-network
<b>Deductible</b>	\$50 per person	\$50 per person	\$35 per person
<b>Annual Out-of-Pocket Maximum</b>	\$450 per person \$900 two or more	\$450 per person \$900 two or more	\$450 per person \$900 two or more
<b>Preventive Dental Services</b> (No waiting period; includes exams, cleanings, X-rays and fluoride)	No charge	No charge	No charge
<b>Basic Dental Services</b> (No waiting period; includes fillings, extractions, periodontal maintenance)	You pay 50% coinsurance after deductible	You pay 50% coinsurance after deductible	You pay 25% coinsurance after deductible
<b>Major Dental Services</b> (No waiting period; root canals, periodontics, crowns, bridges, dentures and dental implants)			You pay 50% coinsurance after deductible
<b>Orthodontia</b> (For medically necessary, non-cosmetic treatment in accordance with Blue Cross of Idaho medical policies; prior authorization required)	You pay 50% coinsurance after deductible	You pay 50% coinsurance after deductible	You pay 50% coinsurance after deductible

19 years of age and older	Dental Choice Core (19 years of age and older)	Dental Choice (19 years of age and older)	Dental Choice Plus (19 years of age and older)
BENEFIT DETAILS	In-network	In-network	In-network
<b>Deductible</b>	\$90 per person	\$75 per person	\$60 per person
<b>Benefit Period Maximum</b>	\$1,000	\$1,000	\$1,250
<b>Preventive Dental Services</b> (Includes exams, cleanings, X-rays and fluoride)	You pay nothing after deductible	No charge	No charge
<b>Basic Dental Services</b> (Includes fillings, extractions, periodontal maintenance); six-month waiting period applies	You pay 50% coinsurance* after deductible	You pay 50% coinsurance after deductible	You pay 20% coinsurance after deductible
<b>Major Dental Services</b> (Includes root canals, periodontics, crowns, bridges, dentures and dental implants); 12-month waiting period applies			You pay 50% coinsurance after deductible

\* Basic Dental Services for Dental Choice Core for 19 years of age and older only covers: fillings, periodontal maintenance, and scaling & root planing.

# Choosing a Dental Plan

Choosing a plan that works best for you and your family is important.

When choosing a plan, consider future expenses like braces, root canals or a crown. Look at the premiums, deductibles, copays and levels of coverage in each plan to ensure you have the coverage you need.

If you have healthy teeth and only need preventive care, your needs will be different than those of a person or family that will require major dental work like braces or crowns. Review the chart below to see the various Blue Cross of Idaho plan options.

Review our 2026 rates at [bcidaho.com/dental](https://bcidaho.com/dental).

	Dental Choice Core	Dental Choice	Dental Choice Plus	Healthy Smiles Copay	Healthy Smiles Preventive	Healthy Smiles Plus	Healthy Smiles Preferred	Healthy Smiles Elite	Dental Blue Connect Individual
<b>Premium</b>	\$	\$\$	\$\$\$	\$\$	\$	\$	\$\$\$	\$\$\$\$	\$\$\$\$
<b>Deductible</b>	●	●	●	●		●	●	●	
<b>Preventive Services</b>	●	●	●	●	●	●	●	●	●
<b>Basic Services</b>	● <sup>1</sup>	●	●	●		●	●	●	●
<b>Major Services</b>	● <sup>2</sup>	●	●	●			●	●	●
<b>Orthodontia</b>	● <sup>3</sup>	● <sup>3</sup>	● <sup>3</sup>						●
<b>Benefit Maximum</b>	●	●	●	● <sup>4</sup>		●	●	●	
<b>Dental Rewards Carryover</b>							●		
<b>Copay plan</b>				●					●
<b>DPPO Network</b>	●	●	●	●	●	●	●	●	Willamette
<b>Waiting Periods</b> Review plan details for waiting period limitations	●	●	●			●	●	●	●
	For age 19 and older								

<sup>1</sup>Select basic services covered for ages over 19.

<sup>2</sup>Major is not covered for ages over 19.

<sup>3</sup>Medically necessary orthodontia only.

<sup>4</sup>Benefit maximum only applies during first benefit period.

# Exclusions and Limitations

In addition to the exclusions and limitations listed elsewhere in the Plan Guide, the following exclusions and limitations apply to the entire Policy, unless otherwise specified.

## I. GENERAL EXCLUSIONS AND LIMITATIONS

There are no benefits for services, supplies, drugs or other charges that are:

- A. Procedures that are not included in the Closed List of Dental Covered Services; or that are not Medically Necessary for the care of an Insured's covered dental condition; or that do not have uniform professional endorsement.
- B. Charges for services that were started prior to the Insured's Effective Date. The following guidelines will be used to determine the date when a service is deemed to have been started:
  - 1. For full dentures or partial dentures: on the date the final impression is taken.
  - 2. For fixed bridges, crowns, inlays or onlays: on the date the teeth are first prepared and final impressions taken.
  - 3. For root canal therapy: on the date the pulp chamber is opened and the canals are explored to the apex.
  - 4. For periodontal Surgery: on the date the Surgery is actually performed.
  - 5. For all other services: on the date the service is performed.
  - 6. For orthodontic services, if benefits are available under this Policy: on the date any bands or other appliances are first inserted.
- C. Cast restorations (crowns, inlays or onlays) for teeth that are restorable by other means (i.e., by amalgam or composite fillings).
- D. Replacement of an existing crown, inlay or onlay that was installed within the preceding seven (7) years or replacement of an existing crown, inlay or onlay that can be repaired.
- E. Appliances, restorations or other services provided or performed solely to change, maintain or restore vertical dimension or occlusion.
- F. A service for cosmetic purposes.
- G. In excess of the Maximum Allowance.
- H. A partial or full removable denture for fixed bridgework, or the addition of teeth thereto, if involving a replacement or modification of a denture or bridgework that was installed during the preceding seven (7) years.
- I. Orthodontic services and supplies unless otherwise specifically listed in the Closed List of Dental Covered Services.
- J. Replacement of lost or stolen appliances.
- K. Any procedure, service or supply required directly or indirectly to treat or diagnose a muscular, neural, orthopedic or skeletal disorder, dysfunction or Disease of the temporomandibular joint (jaw hinge) and its associated structures including, but not limited to, myofascial pain dysfunction syndrome.
- L. Orthognathic Surgery, including, but not limited to, osteotomy, ostectomy and other services or supplies to augment or reduce the upper or lower jaw.
- M. Temporary dental services. Charges for temporary services are considered an integral part of the final dental services and are not separately payable; provisional services will be considered permanent and will have standard replacement frequencies applied.
- N. Any service, procedure or supply for which the prognosis for success is not favorable for at least (3) years from date of service.
- O. Myofunctional therapy and biofeedback procedures.
- P. For hospital Inpatient or Outpatient care for extraction of teeth or other dental procedures.
- Q. Occlusal adjustments, except as specifically listed as a Covered Service in this Policy.
- R. Not prescribed by or upon the direction of a Provider.
- S. Investigational in nature.
- T. Provided for any condition, Disease, Illness or Accidental Injury to the extent that the Insured is entitled to benefits under occupational coverage, obtained or provided by or through the employer under state or federal Workers' Compensation Acts or under Employer Liability Acts or other laws providing compensation for work-related injuries or conditions. This exclusion applies whether or not the Insured claims such benefits or compensation or recovers losses from a third party.
- U. Provided or paid for by any federal governmental entity or unit except when payment under this Policy is expressly required by federal law, or provided or paid for by any state or local governmental entity or unit where its charges therefor would vary, or are or would be affected by the existence of coverage under this Policy; or  
For which payment has been made under Medicare Part A and/or Part B.
- V. Provided for any condition, Accidental Injury, Disease or Illness suffered as a result of any act of war or any war, declared or undeclared.
- W. Furnished by a Provider who is related to the Insured by blood or marriage and who ordinarily dwells in the Insured's household.
- X. Received from a dental, vision or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust or similar person or group.
- Y. For personal hygiene, comfort, beautification or convenience items even if prescribed by a Dentist, including but not limited to, air conditioners, air purifiers, humidifiers, physical fitness equipment or programs.
- Z. For telephone consultations; for failure to keep a scheduled visit or appointment; for completion of a claim form; for interpretation services; or for personal mileage, transportation, food or lodging expenses, or for mileage, transportation, food or lodging expenses billed by a Dentist or other Provider.
- AA. For Congenital Anomalies, or for developmental malformations, unless the patient is an Eligible Dependent child.
- AB. For the treatment of injuries sustained while committing a felony, voluntarily taking part in a riot, or while engaging in an illegal act or occupation, unless such injuries are a result of a medical condition or domestic violence.
- AC. For treatment or other health care of any Insured in connection with an Illness, Disease, Accidental Injury or other condition which would otherwise entitle the Insured to Covered Services under this Policy, if and to the extent those benefits are payable to or due the Insured under any medical payments provision, no fault provision, uninsured motorist provision, underinsured motorist provision, or other first party or no fault provision of any automobile, homeowner's or other similar policy of insurance, contract or underwriting plan.  
In the event Blue Cross of Idaho for any reason makes payment for or otherwise provides benefits excluded by this provision, it shall succeed to the rights of payment or reimbursement of the compensated Provider, the Insured, and the Insured's heirs and personal representative against all insurers, underwriters, self-insurers or other such obligors contractually liable or obliged to the Insured or their estate for such services, supplies, drugs or other charges so provided by Blue Cross of Idaho in connection with such Illness, Disease, Accidental Injury or other condition.
- AD. For which an Insured would have no legal obligation to pay in the absence of coverage under this Policy or any similar coverage; or for which no charge or a different charge is usually made in the absence of insurance coverage; or charges in connection with work for compensation or charges; or for which reimbursement or payment is contemplated under an agreement with a third party.
- AE. Provided to persons who were enrolled as Eligible Dependents after they cease to qualify as Eligible Dependents due to a change in eligibility status which occurs during the Policy term.
- AF. Provided outside the United States, which if had been provided in the United States, would not be Covered Services under this Policy.
- AG. Not directly related to the care and treatment of an actual condition, Illness, Disease or Accidental Injury.
- AH. For acupuncture or hypnosis.
- AI. Denture duplication.
- AJ. Oral hygiene instruction.
- AK. Treatment of jaw fractures.
- AL. Charges for acid etching.
- AM. Charges for oral cancer screening which are included in a regular oral examination.
- AN. No benefits are available for replacement and/or repair of orthodontic appliances. This includes removable and/or fixed retainers.
- AO. Support service(s) provided for a non-Covered Service.

## DISCRIMINATION IS AGAINST THE LAW

Blue Cross of Idaho complies with applicable Federal civil rights laws and does not discriminate, exclude or treat less favorably on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability or sex.

Blue Cross of Idaho:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - o Qualified sign language interpreters
  - o Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English, which may include:
  - o Qualified interpreters
  - o Information written in other languages

If you need these services, contact Blue Cross of Idaho Civil Rights Coordinator at 1-800-627-1188 (TTY: 711).

If you believe that Blue Cross of Idaho 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 at:

Civil Rights Coordinator  
3000 E. Pine Ave., Meridian, ID 83642  
Telephone: 1-800-274-4018  
Fax: 208-331-7493  
Email: [grievancesandappeals@bcidaho.com](mailto:grievancesandappeals@bcidaho.com)  
TTY: 711

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator 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/smartscreen/main.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <https://www.hhs.gov/ocr/complaints/index.html>.

**ATTENTION:** If you speak Arabic, Bantu, Chinese, Farsi, French, German, Japanese, Korean, Nepali, Romanian, Russian, Serbo-Croatian, Spanish, Tagalog, or Vietnamese, appropriate auxiliary aids and language assistance services are available free of charge. Call 1-800-627-1188 (TTY: 711).

**Arabic:** انتبه: إذا كنت تتحدث اللغة العربية ، فإن خدمات المساعدة اللغوية متاحة لك مجاناً اتصل على 1-800-627-1188 (للصم والبكم: 711).

**Bantu:** ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefonta 1-800-627-1188 (TTY: 711).

**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 1-800-627-1188 (TTY:711)。

**Farsi:** توجه: اگر به زبان فارسی صحبت می کنید، خدمات رایگان پشتیبانی زبان، در دسترس شما است. شماره تماس 1-800-627-1188 (TTY:711).

**French:** ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-627-1188 (ATS : 711).

**German:** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-627-1188 (TTY: 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。1-800-627-1188 (TTY:711)まで、お電話にてご連絡ください。

**Korean:** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-627-1188 (TTY: 711)번으로 전화해 주십시오.

**Nepali:** ध्यान दनिहोस: तपाइंले नेपाली बोलनुहुन्छ भने तपाइंको नमिता भाषा सहायता सेवाहरु नि:शुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस 1-800-627-1188 (टटिविडि: 711) ।

**Romanian:** ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-627-1188 (TTY: 711).

**Russian:** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-627-1188 (телетайп: 711).

**Serbo-Croatian:** OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-627-1188 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

**Spanish:** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-627-1188 (TTY: 711).

**Tagalog:** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-627-1188 (TTY: 711).

**Vietnamese:** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-627-1188 (TTY: 711).

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