


**⚠️ 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 1-833-242-3330 or visit us at [www.carpentersfund.org](http://www.carpentersfund.org). For 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 1-833-242-3330 to request a copy.**

| Important Questions   | Answers   | Why This Matters:   |
|---|---|---|
| What is the overall <a href="#">deductible</a> ?                                | \$300 person / \$600 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. In- <a href="#">Network</a> <a href="#">preventive care</a> and any other services listed in SBC that indicate " <a href="#">Deductible</a> waived."   | 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 In- <a href="#">Network</a> <a href="#">providers</a> <b>\$2,000</b> person / <b>\$4,000</b> family, for Out-of- <a href="#">Network</a> <a href="#">providers</a> <b>\$3,200</b> person / <b>\$6,400</b> family. In- <a href="#">Network</a> pharmacy <a href="#">out-of-pocket limit</a> for <a href="#">prescription drugs</a> : <b>\$3,600</b> person / <b>\$7,200</b> family | 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-billed charges</a> , <a href="#">health care</a> this <a href="#">plan</a> doesn't cover, and <a href="#">preauthorization penalties</a> .   | 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://provider.bcbs.com">https://provider.bcbs.com</a> or call: 1-833-242-3330 for a list of In- <a href="#">Network</a> <a href="#">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 plan's <a href="#">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 provider's 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   |
|--|--|--|--|--|
|  |  | In-Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most) |  |
| If you visit a health care <a href="#">provider's office or clinic</a>   | Primary care visit to treat an injury or illness       | \$15 <a href="#">copay</a> per visit<br><a href="#">Deductible</a> waived  | 25% <a href="#">coinsurance</a>                    | ---None---   |
|  | <a href="#">Specialist</a> visit                       | \$15 <a href="#">copay</a> per visit<br><a href="#">Deductible</a> waived  | 25% <a href="#">coinsurance</a>                    | ---None---   |
|  | <a href="#">Preventive care/screening/immunization</a> | No Charge<br><a href="#">Deductible</a> waived   | 25% <a href="#">coinsurance</a>                    | You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for. Age and frequency limitations apply.  |
| If you have a test   | <a href="#">Diagnostic test</a> (x-ray, blood work)    | 20% <a href="#">coinsurance</a>  | 25% <a href="#">coinsurance</a>                    | ---None---   |
|  | Imaging (CT/PET scans, MRIs)                           | 20% <a href="#">coinsurance</a>  | 25% <a href="#">coinsurance</a>                    | ---None---   |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a> | Generic drugs  | 30% <a href="#">coinsurance</a><br>Retail: \$10 minimum / \$20 maximum<br>Mail order:<br>\$25 minimum / \$50 maximum   | Not Covered  | <a href="#">Deductible</a> does not apply.<br><br>Retail limit: 34-day supply.<br>Mail order limit: 90-day supply.   |
|  | Preferred brand drugs                                  | 30% <a href="#">coinsurance</a><br>Retail: \$25 minimum / \$50 maximum<br>Mail order:<br>\$63 minimum / \$125 maximum  | Not Covered  | You pay <a href="#">copay</a> plus difference in cost for brand name drugs where a generic is available. No charge for ACA-required preventive generic drugs (or a brand name preventive drug if the generic drug is not medically appropriate). Maintenance medication after 3 fills must use retail pick up (at CVS only) or mail order. |
|  | Non-preferred drugs                                    | 30% <a href="#">coinsurance</a><br>Retail: \$40 minimum / \$80 maximum<br>Mail order:<br>\$100 minimum / \$300 maximum | Not Covered  |  |
|  | <a href="#">Specialty drugs</a>                        | 30% <a href="#">coinsurance</a><br>\$150 minimum / \$300 maximum   | Not Covered  | <a href="#">Deductible</a> does not apply. Information about <a href="#">specialty drugs</a> is available at <a href="http://www.accredo.com">www.accredo.com</a> .  |

| Common Medical Event  | Services You May Need                            | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information   |
|---|--|---|--|--|
|   |  | In-Network Provider<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most)       |  |
| If you have outpatient surgery  | Facility fee (e.g., ambulatory surgery center)   | 20% <u>coinsurance</u>  | 25% <u>coinsurance</u>                                   | Precertification is required for some outpatient surgeries. Coverage will be denied if precertification is not obtained when required.   |
|   | Physician/surgeon fees                           | 20% <u>coinsurance</u>  | 25% <u>coinsurance</u>                                   |  |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | \$100 <u>copay</u> per visit<br><u>Deductible</u> waived  | \$100 <u>copay</u> per visit<br><u>Deductible</u> waived | <u>Copay</u> waived if admitted.   |
|   | <a href="#">Emergency medical transportation</a> | 20% <u>coinsurance</u>  | 20% <u>coinsurance</u>                                   | <u>Deductible</u> applies first.   |
|   | <a href="#">Urgent care</a>                      | \$15 <u>copay</u> per visit<br><u>Deductible</u> waived   | 25% <u>coinsurance</u>                                   | In-Network <u>deductible</u> and <u>coinsurance</u> apply to services in addition to urgent care visit (e.g. lab work, X-rays).  |
| If you have a hospital stay   | Facility fee (e.g., hospital room)               | 20% <u>coinsurance</u>  | 25% <u>coinsurance</u>                                   | Precertification is required. Coverage will be denied if precertification is not obtained when required.   |
|   | Physician/surgeon fees                           | 20% <u>coinsurance</u>  | 25% <u>coinsurance</u>                                   |  |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | \$15 <u>copay</u> per visit<br><u>Deductible</u> waived;<br>Other outpatient:<br>20% <u>coinsurance</u> | 25% <u>coinsurance</u>                                   | ---None---   |
|   | Inpatient services                               | 20% <u>coinsurance</u>  | 25% <u>coinsurance</u>                                   | Precertification is required. Coverage will be denied if precertification is not obtained when required.   |
| If you are pregnant   | Office visits                                    | No Charge for prenatal care or postnatal care;<br><u>deductible</u> waived.                             | 25% <u>coinsurance</u>                                   | <u>Cost-sharing</u> does not apply for <u>preventive services</u> or prenatal services. Depending on the type of services, <u>coinsurance</u> may apply, Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
|   | Childbirth/delivery professional services        | 20% <u>coinsurance</u>  | 25% <u>coinsurance</u>                                   |  |
|   | Childbirth/delivery facility services            | 20% <u>coinsurance</u>  | 25% <u>coinsurance</u>                                   |  |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>                 | 20% <u>coinsurance</u>  | 25% <u>coinsurance</u>                                   | ---None---   |
|   | <a href="#">Rehabilitation services</a>          | \$15 <u>copay</u> per visit for physical & occupational therapy; <u>deductible</u> waived.              | 25% <u>coinsurance</u>                                   | ---None---   |
|   | <a href="#">Habilitation services</a>            | 20% <u>coinsurance</u> for speech therapy.  |  |  |

| Common Medical Event                          | Services You May Need                     | What You Will Pay                               |   | Limitations, Exceptions, & Other Important Information   |
|---|---|---|---|--|
|   |   | In-Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most)    |  |
|   | <a href="#">Skilled nursing care</a>      | 20% <u>coinsurance</u>                          | 25% <u>coinsurance</u>                                | Precertification is required. Coverage will be denied if precertification is not obtained when required. |
|   | <a href="#">Durable medical equipment</a> | 20% <u>coinsurance</u>                          | 25% <u>coinsurance</u>                                | ---None---   |
|   | <a href="#">Hospice services</a>          | 20% <u>coinsurance</u>                          | 25% <u>coinsurance</u>                                | Precertification is required. Coverage will be denied if precertification is not obtained when required. |
| <b>If your child needs dental or eye care</b> | Children's eye exam                       | No Charge<br><u>Deductible</u> waived           | Reimbursement of the <u>allowed amount</u> up to \$50 | Limited to one exam per 12 months. Vision benefits are administered by EyeMed.                           |
|   | Children's glasses                        | No Charge<br><u>Deductible</u> waived           | Reimbursement up to the <u>allowed amount</u>         | Limited to two pairs per 12 months. Vision benefits are administered by EyeMed.                          |
|   | Children's dental check-up                | No Charge<br><u>Deductible</u> waived           | No Charge up to <u>allowed amount</u>                 | Limited to two exams per year. Dental benefits are administered by Delta Dental.                         |

#### Excluded Services & Other Covered Services:

##### Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- Cosmetic surgery
- Gym memberships
- Long Term Care
- Private-duty nursing
- Weight loss programs (Except as required by ACA)

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

- Acupuncture
- Bariatric surgery
- Chiropractic care (20 visits per calendar year)
- Dental care (Adult) (Administered by Delta Dental)
- Hearing Aids (Limit of \$1,500 per ear per year for individuals up to age 19, \$1,500 per ear per 3 years for individuals over age 19. Administered by TRUHearing)
- Infertility Treatment
- Non-emergency care when traveling outside the U.S. (See [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com))
- Routine eye care (Adult) (Administered by EyeMed)
- Routine foot care (only for patients with systemic circulatory disease)

**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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.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 [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: 1-833-242-3330 or [www.carpentersfund.org](http://www.carpentersfund.org). You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**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:

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-844-864-4352 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-864-4352 (TTY: 711).

注意: 如果您使用简体中文, 您可以免费获得语言协助服务。请致电1-844-864-4352。

LƯU Ý: Nếu quý vị nói tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho quý vị. Xin gọi số 1-844-864-4352.

ВНИМАНИЕ: Если вы говорите по-русски, вам предлагаются бесплатные услуги переводчика. Позвоните по телефону 1-844-864-4352.

Wann du [Deutsch (Pennsylvania German / Dutch)] schwetzsch, kannsch du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-844-864-4352.

알림: 한국어 통역서비스가 필요한 분은 1-844-864-4352로 전화하십시오.

통역서비스를 무료로 받으실 수 있습니다.

ATTENZIONE: se parla italiano, sono disponibili per lei servizi di assistenza linguistica gratuiti. Contatti il numero 1-844-864-4352.

انتباه: إذا كنت تتحدث العربية فإن خدمات المساعدة اللغوية متوفرة لك مجاناً. اتصل على الرقم: 1-844-864-4352.

ATTENTION: Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Appelez le 1-844-864-4352.

HINWEIS: Wenn Sie Deutsch sprechen, steht Ihnen über Language Assistance Services ein Dolmetscher kostenlos zur Verfügung. Wählen Sie 1-844-864-4352.

ધ્યાન આપો : જો તમે ગુજરાતી બોલી શકતા હો, તો તમારા માટે ભાષા સહાય સેવાઓ, વિના મૂલ્યે, ઉપલબ્ધ છે. 1-844-864-4352 પર કોલ કરો.

UWAGA: jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-864-4352.

ATANSYON: Si ou pale kreyòl ayisyen, gen asistans ak lang disponib pou ou gratis. Rele 1-844-864-4352.

ចំណាំ: ប្រសិនបើអ្នកនិយាយភាសា មន-ខ្មែរ ឬទេសខ្មែរ សេវាជំនួយភាសាដែលឥតគិតថ្លៃមានសម្រាប់អ្នក។ សូមទូរស័ព្ទមកលេខ 1-844-864-4352។

ATENÇÃO: se você fala português, serviços de assistência a idioma estão disponíveis gratuitamente para você. Ligue para 1-844-864-4352.

BAA !KON&N&ZIN: Din4 bizaad bee yIn7[ti'go, ata' hane' bee Ik1 i'iilyeed t'11 j77k'e bee n1 ah00t'i'. Koj8' hod77Inih 1-844-864-4352.

PAUNAWA: Kung nagsasalita ka ng Tagalog, makakakuha ka ng mga serbisyo ng tulong para sa wika nang walang bayad. Tumawag sa 1-844-864-4352.

注意: 日本語をお話しになる場合は、言語支援サービスを無料でご利用いただけます。1-844-864-4352にお電話ください。

توجه: اگر به زبان فارسی صحبت می کنید، خدمات کمک در زمینه زبان، به رایگان در اختیار شما می باشد. با شماره 1-844-864-4352 تماس بگیرید.

—————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> | \$300 |
| ■ <a href="#">Specialist copayment</a>                          | \$15  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%   |
| ■ Other <a href="#">coinsurance</a>                             | 20%   |

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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$300          |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$1,700        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$2,060</b> |

### 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> | \$300 |
| ■ <a href="#">Specialist copayment</a>                          | \$15  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%   |
| ■ Other <a href="#">coinsurance</a>                             | 20%   |

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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$300          |
| <a href="#">Copayments</a>        | \$200          |
| <a href="#">Coinsurance</a>       | \$1,200        |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,720</b> |

### Mia's Simple Fracture

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

|   |       |
|---|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$300 |
| ■ <a href="#">Specialist copayment</a>                          | \$15  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%   |
| ■ Other <a href="#">coinsurance</a>                             | 20%   |

This EXAMPLE event includes services like:

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

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                      |              |
|-----------------------------------|--------------|
| <a href="#">Deductibles</a>       | \$300        |
| <a href="#">Copayments</a>        | \$300        |
| <a href="#">Coinsurance</a>       | \$200        |
| What isn't covered                |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$800</b> |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

## **Nondiscrimination Notice and Notice of Availability of Auxiliary Aids and Services**

Independence Administrators complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Independence Administrators does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Independence Administrators:

- Provides free aids and services to people with disabilities to communicate effectively with us and written information in other formats, such as large print
- Provides free language services to people whose primary language is not English and information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Independence Administrators 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 our Civil Rights Coordinator.

There are four ways to file a grievance directly with Independence Administrators:

- by mail: Independence Administrators,  
ATTN: Civil Rights Coordinator, 1900 Market Street, Philadelphia, PA 19103;
- by phone: 844-864-4352 (TTY 711);
- by fax: 215-761-0920; or
- by email: [IACivilRightsCoordinator@ibxtpa.com](mailto:IACivilRightsCoordinator@ibxtpa.com).

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/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, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.