Coverage Period: 01/01/2023-12/31/2023
Coverage for: Individual/Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 <u>www.bcbstx.com</u> or by calling 1-855-357-5228 For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/ or call 1-800-456-5974 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: \$1,000 Individual / \$2,000 Family Out-of-Network: \$1,500 Individual / \$3,000 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible?</u>	Yes. Services that charge a <u>copay</u> , <u>prescription</u> drugs, and <u>In-Network diagnostic tests</u> , <u>home</u> <u>health</u> , <u>skilled nursing</u> , and <u>hospice</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In-Network: \$3,500 Individual / \$7,000 Family Out-of-Network: \$9,000 Individual / \$18,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the <u>out-of-pocket limit?</u>	<u>Deductibles, premiums, preauthorization</u> penalties, <u>balance-billed</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.bcbstx/com or call 1-855-357-5228 for a list of In-Network providers.	This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your plan pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)

(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

Do you need	a <u>referral</u> to
see a speciali	ist?

No.

You can see the <u>specialist</u> you choose without a <u>referral</u>.



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common		What You Will Pay		Limitations, Exceptions, & Other Important	
Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Information	
	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	Virtual visits available through MDLive \$0 copay. In-Network.	
If you visit a health care <u>provider's</u> office	<u>Specialist</u> visit	\$35 <u>copay</u> /visit; <u>deductible</u> does not apply	30% coinsurance	None	
or clinic	Preventive care/screening/ immunization	No Charge; deductible does not apply	30% coinsurance	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. No Charge for child immunizations Out-of-Network through the 6th birthday.	
Marco bassa a 40 a 4	<u>Diagnostic test</u> (x-ray, blood work)	No Charge; deductible does not apply	30% coinsurance	Office visit <u>copay</u> may apply.	
If you have a test	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None	

All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

Common		What You Will Pay		Limitations, Exceptions, & Other Important	
Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Information	
	Tier 1	Retail: \$10 copay / prescription Mail: \$20 copay / prescription; deductible does not apply	Total Cost of prescription		
If you need drugs to treat your illness or condition More information about	Tier 2	Retail: 20% with \$25 min / \$100 max per 30-day prescription Mail: 20% with \$50 min /\$200 max per 90-day prescription	Total Cost of prescription	Retail: one <u>copay</u> per 30-day supply Retail -90: two <u>copays</u> up to 90 day supply Mail: two <u>copays</u> up to 90-day supply. Members electing to purchase brand name drugs when a generic is available will be required to pay the difference between the cost of the Generic drug and Brand Name drug, plus the Brand Name <u>Copayment</u> . <u>Specialty drug</u> prescriptions must be filled through Lumicera Specialty Pharmacy. One <u>copay</u> per 30-day supply.	
prescription drug coverage is available at www.mybenefits.org	Tier 3	Retail: 20% with \$40 min / \$100 max per 30-day prescription Mail: 20% with \$80 min /\$200 max per 90-day prescription	Total Cost of prescription		
	Specialty drugs	20% with \$25 min / \$100 max per prescription 20% with \$40 min / \$100 max per prescription	Total Cost of prescription		
If you have	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	70% coinsurance	None	
outpatient surgery	Physician/surgeon fees	20% coinsurance	70% coinsurance		
If you need immediate medical	Emergency room care	20% <u>coinsurance</u> after \$150 <u>copay</u> /visit	20% <u>coinsurance</u> after \$150 <u>copay</u> /visit	Copay waived if admitted.	
attention	Emergency medical transportation	20% coinsurance	20% coinsurance	None	

All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

Common		What You Will Pay		Limitations, Exceptions, & Other Important	
Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Information	
	Urgent care	\$50 <u>copay</u> /visit; <u>deductible</u> does not apply	70% coinsurance	None	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	70% coinsurance	All services must be preauthorized; \$250 penalty applies. <u>Out-of-Network</u> for failure to preauthorize.	
o.i.y	Physician/surgeon fees	20% coinsurance	70% coinsurance	None	
If you need mental	Outpatient services	\$25/\$35 copay / office visit; deductible does not apply 20% coinsurance for other outpatient services	70% coinsurance office visit 70% coinsurance for other outpatient services	Limited to 30 visits per plan year. Substance abuse treatment limited to 3 series per lifetime. Certain services must be preauthorized; refer to benefit booklet for details.	
health, behavioral health, or substance abuse services	Inpatient services	20% coinsurance	70% coinsurance	Limited to 30 days per plan year. Substance abuse treatment limited to 3 series per lifetime. All services must be preauthorized; \$250 penalty applies Out-of-Network for failure to preauthorize.	
	Office visits	\$25/35 <u>copay</u> / initial visit; <u>deductible</u> does not apply	70% coinsurance	20% <u>coinsurance</u> applies after initial visit In- Network. <u>Cost sharing</u> does not apply for preventive services.	
If you are pregnant	Childbirth/delivery professional services	20% <u>coinsurance</u>	70% coinsurance	Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	70% coinsurance	All services must be preauthorized; \$250 penalty applies <u>Out-of-Network</u> for failure to preauthorize.	



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Camman		What You Will Pay		Limitations Expontions & Other Importan	
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Home health care	No Charge; deductible does not apply	70% coinsurance	Limited to 60 visits per <u>plan</u> year. All services must be preauthorized.	
	Rehabilitation services	\$25/\$35 copay / visit; deductible does not apply	70% coinsurance	None	
If you need help recovering or have other special health	Habilitation services	\$25/\$35 copay / visit; deductible does not apply	70% coinsurance	None	
needs	Skilled nursing care	No Charge; <u>deductible</u> does not apply	70% coinsurance	Limited to 25 days per plan year. All services must be preauthorized.	
	Durable medical equipment	20% coinsurance	70% coinsurance	None	
	Hospice services	No Charge; deductible does not apply	70% coinsurance	All services must be preauthorized.	
If your child needs	Children's eye exam	No Charge; deductible does not apply	70% coinsurance	None	
dental or eye care	Children's glasses	Not Covered	Not Covered	INOTIC	
	Children's dental check-up	Not Covered	Not Covered		

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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)

- Hearing Aids
- Infertility treatment
- Long-term care

- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)

Chiropractic care

- Non-emergency care when traveling Outside the U.S.
- Routine eye care (Adult)

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: the plan at 1-855-357-5228, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 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: Blue Cross Blue Shield of Texas at 1-855-357-5228 or visit www.bcbstx.com, or contact the U.S. Department of Labor's Employee Benefits Security Administrations at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Contact the Texas Department of Insurance at 1-800-252-3439 or visit www.texashealthoptions.com.

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 <u>plan</u> doesn't meet the <u>Minimum Value Standards</u>, you may be eligible for a <u>premium tax credit</u> to help you pay for a <u>plan</u> through the <u>Marketplace</u>.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-855-357-5228.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-357-5228.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-357-5228.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-357-5228.]

To see examples of how the 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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 <u>plan's</u> overall <u>deductible</u>	\$3,000
Specialist copayment	\$50
■ Hospital (facility) coinsurance	20%
Other coinsurance	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)

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$3,000
■ Specialist copayment	\$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:

Primary care physician office visits (including disease education)
Diagnostic tests (blood work)
Prescription drugs

\$7,400

Durable medical equipment (glucose meter)

Total Example Cost

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$3,000
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	20%
Other coinsurance	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)

Total Example Cost

Total Example Cost	\$12,800
In this example, Peg would pay:	
Cost Sharing	
Deductibles	\$3,000
Copayments	\$70
Coinsurance	\$1,700

What isn't covered

Limits or exclusions

The total Peg would pay is

\$3,000
\$70
\$1,700
\$60
\$4,830

In this example, Joe would pay:	
Cost Sharing	
Deductibles	\$2,000
Copayments	\$1,100
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$3,160

In this example, Mia would pay:	
Cost Sharing	
Deductibles	\$1,100
Copayments	\$500
Coinsurance	\$0
1471 (! !! . !	

What isn't covered

Limits or exclusions \$0

The total Mia would pay is \$1,600

Note: These numbers assume the patient does not participate in the <u>plan's</u> wellness program. If you participate in the <u>plan's</u> wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact:1-855-357-5228.

*Note: This plan has other <u>deductibles</u> for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

\$1.900

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To speak to an interpreter, call the customer service number on the back of your member card. If you are not a member, or don't have a card, call 855-710-6984.

نا ناك كديدا وأ ندا صخشه هدعاسة تمانساً، كيدافى قحاا في لوصحاً على ةدعاسما تامولعمالو تميرورضاً كتغلب ن منود تميا تكلفة. ثدحتاً لى إلم مجرته يروف، لصنا على مقر تمدذ علامعاً روكذماً على ريهظ تقاطب كتيوضـــع. ن إفي مها نكة عضـــاق، وأ تنك
لا كلمة قفاطب، لصناف على 6984-710-855.
如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請致電印在您的會員卡背面的客戶服務電話號碼。如果您不是會員, 或沒有會員卡, 請致電 855-710-6984。
Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, composez le numéro du service client indiqué au verso de votre carte de membre. Si vous n'êtes pas membre ou si vous n'avez pas de carte, veuillez composer le 855-710-6984.
Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Kundenservicenummer auf der Rückseite Ihrer Mitgliedskarte an. Falls Sie kein Mitglied sind oder keine Mitgliedskarte besitzen, rufen Sie bitte 855-710-6984 an.
જો તમને અથવા તમે મદદ કર≬ રહ્યા હોય એવી કોઈ બી� વ્ય¢ક્તને એસ.બી.એમ. �ુ ભાિષયા સાથે વાત કરવા માં⁄¢, તમારા સભ્યપદના કાડર,ની પાછળ આપેલ ગ્રાહક સેવા નબ્ર ૨૫૨ કૉલ કરો. જો આપ સભ્યપદ ના ધરાવતા હોવ, અથવા આપની પાસે કાડર્ નથી તો 855-710-6984 નબ્ર ૨૫૨ કૉલ કરો.
य�्द आपक्टे, या आप िजसक≬ सहायता कर रहे क़ॗ उसक्टे, प्रश्न क़ॢ, तो आपको अपनी भाषा फ़ॄ �नःशुल्क सहायता और जानकार≬ प्राप्त करने का अ�धकार है। �कसी अनुवादक से बात करने के �लए, अपने सदस्य काडर् के पीछे �दए गए प्राहक सेवा नंबर पर कॉल कर�। य�द आप सदस्य नह्∳ं क़, या आपके पास काडर् नह्∳ं है, तो 855-710-6984 पर कॉल कर�।
ご本人様、またはお客様の身の回りの方でも、ご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、メンバーカードの裏のカスタマーサービス番号までお電話ください。メンバーでない場合またはカードをお持ちでない場合は 855-710-6984 までお電話ください。
만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 회원 카드 뒷면에 있는고객 서비스 번호로 전화하십시오. 회원이 아니시거나 카드가 없으시면 855-710-6984 으로 전화주십시오.
ຖ້ າທ່ານ ືຫຼ ຄຸນຽທທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼອີມໍຄາຖາມ, ທ່ານຽມິສດໍຂເົອາການຊ່ວຍເຫຼອ ແລະໍຂມູນເປັນນພາສາຂອງທ່ານໄດ້ ໂດຍໍບີມຄ່າໃຊ້ຈ່າຍ. ເພື ອຊີມກັບນາຍແປີພາສາ, ໃຫ້ ໂທຫາເວັບຝ່າຍໍບິລ ການລູກຄ້າີທີມຢູ່ ດ້ານຫັງ ປັດສະມາິຊົກຂອງທ່ານ. ຖ້າທ່ານໍບແມ່ນສະມາິຊກ, ືຫຼ່ບວີມປັດ, ໃຫ້ ໂທຫາເວັບ 855- 7/10-6984.
T'11 ni, 47 doodago [a'da b7k1 an1n7lwo'7g77, na'7d7[kidgo, ts'7d1 bee n1 ah00ti'i' t'11 n77k'e n7k1 a'doolwo[. Ata' halne'7 bich'8' hadeesdzih n7n7zingo 47 kwe'4 da'7n7ishgi 1k1 an7daalwo'7g77 bich'8' hod77lnih, bee n44h0zinii bine'd66' bik11'. Koj7 atah naaltsoos n1 had7t'44g00 47 doodago bee n44h0zin7g77 1dingo koj8' hod77lnih 855-710-6984.
رگا امش، به شما که کسی یا وا می کمک دینک، یالؤسه نتشاد دیشاب، ق ح نیا ار دیراد به که نابز دوخ، به روط ناگیار کمک و تاعلاطا تغایرد دییامنـ تهج و گنفگ یک با مجرتمـ یهافش، با تنامدخ یرتشمـ به هر امشـ یا که رد ت شپـ تراک ت بوضـع دیرادن، با هر امشـ 898-710-7558 سامة ل صاحـ دییامنـ
Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы поговорить с переводчиком, позвоните в отдел обслуживания клиентов по телефону, указанному на обратной стороне вашей карточки участника. Если вы не являетесь участником или у вас нет карточки, позвоните по телефону 855-710-6984.
Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete comuníquese con el número del Servicio al Cliente que figura en el reverso de su tarjeta de miembro. Si usted no es miembro o no posee una tarjeta, llame al 855-710-6984.
Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa numero ng serbisyo para sa kustomer sa likod ng iyong kard ng miyembro. Kung ikaw ay hindi isang miyembro, o kaya ay walang kard, tumawag sa 855-710-6984.
رگا پآ وک کسی یا ہےسیا درفوک سجکی پآ ددم ہے ہررک ںیب یائوک لاوس شیپرد ہے وت پآ وک ینپا نابز رہم تخہ ددم روا تنامولعہ لصاحےنرک کا قحے ہمجرتہ سے تنابےنرک کے ہےیا، رمٹسک سورسر بمذر پر لہاکا ںیرک وج پآ کے ٹراک کی تشدر پر جرد ہے برگا پآ ربمہ ںیبنہ یا پآ کے ساپ ٹراک ریبذ ہے وت، 1984-710-858 رپر لہاکا ںیرک
Nếu quý vị hoặc người mà quý vị giúp đỡ có bất kỳ câu hỏi nào, quý vị có quyền được hỗ trợ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, gọi số dịch vụ khách hàng nằm ở phía sau thẻ hội viên của quý vị. Nếu quý vị không phải là hội viên hoặc không có thẻ, gọi số 855-710-6984.

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator Phone: 855-664-7270 (voicemail)

300 E. Randolph St. TTY/TDD: 855-661-6965 35th Floor Fax: 855-661-6960

Chicago, Illinois 60601 Email: <u>CivilRightsCoordinator@hcsc.net</u>

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services Phone: 800-368-1019 200 Independence Avenue SW TTY/TDD: 800-537-7697

Room 509F, HHH Building 1019 Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Washington, DC 20201 Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html