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 1-800-624-2414. 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 www.emblemhealth.com or call 1-800-624-2414 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$1,700 Individual / $3,400 Family in network providers. Does not apply to preventive care and generic drugs.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive care, prenatal care and telemedicine are covered before you meet your deductible.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>For in network providers $7,500 Individual / $15,000 Family.</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, penalties, balanced-bill charges, and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.EmblemHealth.com">www.EmblemHealth.com</a> or call 1-800-447-8255 for a list of participating providers.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>Yes.</td>
<td>This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>After Plan deductible is met, $30 co-pay per visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>After Plan deductible is met, $30 co-pay per visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td><strong>Diagnostic test</strong> (x-ray, blood work)</td>
<td>After Plan deductible is met, PCP Office: $30 co-pay per visit Specialist Office: $50 co-pay per visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Imaging</strong> (CT/PET scans, MRIs)</td>
<td>After Plan deductible is met, $50 co-pay per visit</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td><strong>Generic drugs</strong> (Tier 1)</td>
<td>Retail: $10 co-pay/30 day supply Mail Order: $25 co-pay/90 day supply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Preferred brand drugs</strong> (Tier 2)</td>
<td>Retail: $35 co-pay/30 day supply Mail Order: $87.50 co-pay/90 day supply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Non-preferred brand drugs</strong> (Tier 3)</td>
<td>Retail: $70 co-pay/30 day supply Mail Order: $175 co-pay/90 day supply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Specialty drugs</strong> (Tier 4)</td>
<td>Tier 1: $10 co-pay/30 day supply Tier 2: $35 co-pay/30 day supply Tier 3: $70 co-pay/30 day supply</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at [www.emblemhealth.com/sbc](http://www.emblemhealth.com/sbc).
<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>After Plan deductible is met, $100 co-pay per visit</td>
<td>Prior Approval required. Failure to obtain Prior Approval will result in denial of payment or reduced payment.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>After Plan deductible is met, $100 co-pay per visit</td>
<td>Prior Approval required. Failure to obtain Prior Approval will result in denial of payment or reduced payment.</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care</td>
<td>After Plan deductible is met, $250 co-pay per visit</td>
<td>Waived if admitted.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>After Plan deductible is met, $150 co-pay per visit</td>
<td>-----None-----</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>After Plan deductible is met, $70 co-pay per visit</td>
<td>In network only</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>After Plan deductible is met, $1,500 per admission</td>
<td>Prior Approval required. Failure to obtain Prior Approval will result in denial of payment or reduced payment. However, Prior Approval is not required for emergency admissions.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>After Plan deductible is met, $100 co-pay per visit</td>
<td>Prior Approval required. Failure to obtain Prior Approval will result in denial of payment or reduced payment.</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>After Plan deductible is met, $30 co-pay per visit</td>
<td>Unlimited visits. For Substance Abuse care, up to twenty (20) visits per plan year may be used for family counseling.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>After Plan deductible is met, $1,500 per admission</td>
<td>Prior Approval required. Failure to obtain Prior Approval will result in denial of payment or reduced payment. However, Prior Approval is not required for emergency admissions.</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at [www.emblemhealth.com/sbc](http://www.emblemhealth.com/sbc).
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<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>After Plan deductible is met, $100 co-pay per visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>After Plan deductible is met, $1,500 per admission</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA will use the cost sharing for the appropriate service.

Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Depending on the type of service, a copayment, coinsurance or deductible may apply.

Limited to forty-eight (48) hours for natural delivery and ninety-six (96) hours for caesarean delivery. Prior Approval required. Failure to obtain Prior Approval will result in denial of payment or reduced payment.

* For more information about limitations and exceptions, see the plan or policy document at [www.emblemhealth.com/sbc](http://www.emblemhealth.com/sbc).
<table>
<thead>
<tr>
<th>Common Medical Event</th>
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<tr>
<td></td>
<td></td>
<td>Network Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td><strong>Home health care</strong></td>
<td>After Plan deductible is met, $30 co-pay per visit</td>
<td>Not covered</td>
<td>Forty (40) visits per plan year. Home infusion counts toward home health care visit limits. Prior Approval required. Failure to obtain Prior Approval will result in denial of payment or reduced payment.</td>
</tr>
<tr>
<td><strong>Rehabilitation services</strong></td>
<td>After Plan deductible is met Inpatient: $1,500 per admission Outpatient: $30 co-pay per visit</td>
<td>Not covered</td>
<td>Inpatient: Sixty (60) days per plan year. Combined therapies. Outpatient: Sixty (60) visits per condition per plan year. Combined therapies. Speech and physical therapy are only covered following a hospital stay or surgery. Prior Approval required. Failure to obtain Prior Approval will result in denial of payment or reduced payment.</td>
</tr>
<tr>
<td><strong>Habilitation services</strong></td>
<td>After Plan deductible is met Inpatient: $1,500 per admission Outpatient: $30 co-pay per visit</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td><strong>Skilled nursing care</strong></td>
<td>After Plan deductible is met, $1,500 per admission</td>
<td>Not covered</td>
<td>200 days per plan year. Prior Approval required. Failure to obtain Prior Approval will result in denial of payment or reduced payment.</td>
</tr>
<tr>
<td><strong>Durable medical equipment</strong></td>
<td>After Plan deductible is met, 30% coinsurance</td>
<td>Not covered</td>
<td>One (1) external prosthetic device per limb per lifetime. No orthotics. Prior Approval required. Failure to obtain Prior Approval will result in denial of payment or reduced payment.</td>
</tr>
<tr>
<td><strong>Hospice services</strong></td>
<td>After Plan deductible is met, Inpatient: $1,500 per admission Outpatient: $30 co-pay per visit</td>
<td>Not covered</td>
<td>210 days per plan year. Five (5) visits for family bereavement counseling. Prior Approval required. Failure to obtain Prior Approval will result in denial of payment or reduced payment.</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at [www.emblemhealth.com/sbc](http://www.emblemhealth.com/sbc).
<table>
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<tr>
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<th>Services You May Need</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td><strong>Network Provider</strong></td>
<td><strong>Out-of-Network Provider</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td>Children’s eye exam</td>
<td>After Plan deductible is met, $30 co-pay per visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>After Plan deductible is met, 30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>After Plan deductible is met, $30 co-pay per visit</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at [www.emblemhealth.com/sbc](http://www.emblemhealth.com/sbc).
**Excluded Services & Other Covered Services:**

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
</table>
| • Acupuncture  
• Cosmetic surgery  
• Dental care (Adult)  
• Long-term care  
• Most coverage provided outside the United States  
• Non-emergency care when traveling outside the U.S.  
• Private-duty nursing  
• Routine eye care (Adult)  
• Routine foot care  
• Weight loss programs  
• Abortion services  
• Bariatric surgery (Prior Approval required)  
• Chiropractic care  
• Hearing aids (Prior Approval required)  
• Infertility treatment (Prior Approval required)  
• Routine eye care (Adult)  
• Routine foot care  
• Weight loss programs |

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

| • Abortion services  
• Bariatric surgery (Prior Approval required)  
• Chiropractic care  
• Hearing aids (Prior Approval required)  
• Infertility treatment (Prior Approval required) |

**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: New York State Department of Financial Services at 1-800-342-3736 or [www.dfs.ny.gov](http://www.dfs.ny.gov), U.S. Department of Health and Human Services at 1-877-267-2323 x1565 or [www.cciio.cms.gov](http://www.cciio.cms.gov), U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/contactEBSA/consumerassistance.html](http://www.dol.gov/ebsa/contactEBSA/consumerassistance.html) 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](http://www.HealthCare.gov). For more information about the [Marketplace](http://www.HealthCare.gov), 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 right, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information 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:

**EmblemHealth**

**By Phone:**
Please call the number on your ID card.

**In writing:**
EmblemHealth  
Grievance and Appeals Department  
P.O. Box 2801  
New York, NY 10116-2807  
Website: [www.emblemhealth.com](http://www.emblemhealth.com)

**For All Coverage Types**

**New York State Department of Financial Services**

**By Phone:** 1-800-342-3736

**In writing:**
New York State Department of Financial Services  
Consumer Assistance Unit  
One Commerce Plaza  
Albany, NY 12257  
Website: [www.dfs.ny.gov](http://www.dfs.ny.gov)

* For more information about limitations and exceptions, see the plan or policy document at [www.emblemhealth.com/sbc](http://www.emblemhealth.com/sbc).
**For HMO Coverage**
New York State Department of Health  
**By Phone:** 1-800-206-8125  
**In writing:**  
New York State Department of Health  
Office of Health Insurance Programs  
Bureau of Consumer Services – Complaint Unit  
Corning Tower – OCP Room 1607  
Albany, NY 12237  
Email: managedcarecomplaint@health.ny.gov  
Website: www.health.ny.gov

**Consumer Assistance Program**
New York State Consumer Assistance Program  
**By Phone:** 1-888-614-5400  
**In writing:**  
Community Health Advocates  
633 Third Avenue, 10th Floor  
New York, NY 10017  
Email: cha@cssny.org  
Website: www.communityhealthadvocates.org

**For Group Coverage:**
U.S. Department of Labor  
Employee Benefits Security Administration at 1-866-444-EBSA (3272)  
Website: www.dol.gov/ebsa/healthreform

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**Does this plan provide Minimum Essential Coverage?** Yes  
If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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:**
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-624-2414  
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-624-2414  
Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 1-800-624-2414  
Navajo (Dine): Dinek’ehgo shika at’ohwol ninisingo, kwiijigo holne’ 1-800-624-2414

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*For more information about limitations and exceptions, see the plan or policy document at [www.emblemhealth.com/sbc](http://www.emblemhealth.com/sbc).*
**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

<table>
<thead>
<tr>
<th>Peg is having a baby (9 months of in-network pre-natal care and a hospital delivery)</th>
<th>Managing Joe’s type 2 diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia’s Simple Fracture (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The plan’s overall deductible</strong></td>
<td>$1,700</td>
<td>$1,700</td>
</tr>
<tr>
<td><strong>Specialist (cost sharing)</strong></td>
<td>$50</td>
<td>$50</td>
</tr>
<tr>
<td><strong>Hospital (facility) cost sharing</strong></td>
<td>$1,500</td>
<td>$1,500</td>
</tr>
<tr>
<td><strong>Other cost sharing</strong></td>
<td>$60</td>
<td>$55</td>
</tr>
<tr>
<td><strong>This EXAMPLE event includes services like:</strong></td>
<td><strong>This EXAMPLE event includes services like:</strong></td>
<td><strong>This EXAMPLE event includes services like:</strong></td>
</tr>
<tr>
<td>Specialist office visits (prenatal care)</td>
<td>Childbirth/Delivery Professional Services</td>
<td>Emergency room care (including medical supplies)</td>
</tr>
<tr>
<td>Childbirth/Delivery Facility Services</td>
<td>Diagnostic tests (ultrasounds and blood work) Specialist visit (anesthesia)</td>
<td>Diagnostic test (x-ray)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Durable medical equipment (crutches)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rehabilitation services (physical therapy)</td>
</tr>
<tr>
<td><strong>Total Example Cost</strong></td>
<td>$12,800</td>
<td>$7,400</td>
</tr>
<tr>
<td><strong>In the example, Peg would pay:</strong></td>
<td><strong>In the example, Joe would pay:</strong></td>
<td><strong>In the example, Mia would pay:</strong></td>
</tr>
<tr>
<td><strong>Cost Sharing</strong></td>
<td><strong>Cost Sharing</strong></td>
<td><strong>Cost Sharing</strong></td>
</tr>
<tr>
<td>Deductibles</td>
<td>$1,503</td>
<td>Deductibles</td>
</tr>
<tr>
<td>Copayments</td>
<td>$5,247</td>
<td>Copayments</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
<td>Coinsurance</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td></td>
<td><strong>What isn’t covered</strong></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$60</td>
<td>Limits or exclusions</td>
</tr>
<tr>
<td><strong>The total Peg would pay is</strong></td>
<td><strong>The total Joe would pay is</strong></td>
<td><strong>The total Mia would pay is</strong></td>
</tr>
<tr>
<td>$6,810</td>
<td>$2,535</td>
<td>$2,098</td>
</tr>
</tbody>
</table>

Note: These numbers assume the patient does not participate in the plan’s wellness program. If you participate in the plan’s wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact 1-800-318-2596.

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

The plan would be responsible for the other costs of these EXAMPLE covered services.
ATTENTION: Language assistance services, free of charge, are available to you. Call 1-877-411-3625 (TTY/TDD: 711).

Español (Spanish)

中文 (Traditional Chinese)
注意：我們免費提供相關的語言協助服務。請致電 1-877-411-3625 (TTY/TDD: 711)。

Русский (Russian)

Kreyòl Ayisyen (Haitian Creole)

한국어 (Korean)

Italiano (Italian)

זִיוּדִיש (Yiddish)

বাংলা (Bengali)
মনোনোগ দিল: ভাষা সহায়তা পরিষেবাগুলি আপনার জন্য বিনামূল্য উপলব্ধ আছে। 1-877-411-3625(TTY/TDD: 711) নম্বরে ফোন করুন।

Polski (Polish)

العربية (Arabic)
يرجى الانتباه: تتوفر لك خدمات المساعدة اللغوية مجانا، اتصل على الرقم 1-877-411-3625 أو (TTY/TDD: 711).

Français (French)
NOTICE OF NONDISCRIMINATION POLICY

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

EmblemHealth:
- Provides free aids and services to people with disabilities to help
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose first language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call member services at 1-877-411-3625 (TTY/TDD: 711).

If you believe that EmblemHealth 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 EmblemHealth Grievance and Appeals Department, PO Box 2844, New York, NY 10116, or call member services at 1-877-411-3625. (Dial 711 for TTY/TDD services.) You can file a grievance in person, by mail or by phone. If you need help filing a grievance, EmblemHealth’s Grievance and Appeals Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office of Civil Rights electronically through the Office of Civil Rights Complaint Portal, available at 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, (dial 1-800-537-7697 for TTY services).

Complaint forms are available at hhs.gov/ocr/office/file/index.html.