**Important Questions** | **Answers** | **Why this Matters:**
--- | --- | ---
**What is the overall deductible?** | $7,690 Individual / $15,380 Family in network providers. Does not apply to preventive care. | 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. 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 and before you meet your deductible. See a list of covered preventive services at [https://www.healthcare.gov/coverage/preventive-care-benefits/](https://www.healthcare.gov/coverage/preventive-care-benefits/).

**Are there services covered before you meet your deductible?** | Yes. Three primary care office visits, urgent care center, lab services preventive care, prenatal care, telemedicine and generic drugs are covered before you meet your deductible. | 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 and before you meet your deductible. See a list of covered preventive services at [https://www.healthcare.gov/coverage/preventive-care-benefits/](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 out-of-pocket limit for this plan?** | For in network providers $7,690 Individual / $15,380 Family. | 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.

**What is not included in the out-of-pocket limit?** | Premiums, penalties, balanced-bill charges, and health care this plan 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 network provider?** | Yes. See [www.EmblemHealth.com](http://www.EmblemHealth.com) or call 1-800-447-8255 for a list of participating providers. | 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.

**Do you need a referral to see a specialist?** | Yes. | 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.
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></td>
<td></td>
<td><strong>Network Provider</strong> (You will pay the least)</td>
<td><strong>Out-of-Network Provider</strong> (You will pay the most)</td>
</tr>
<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>First 3 visits, No charge. Thereafter, No charge after Plan deductible is met</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>After Plan deductible is met, No charge</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>Diagnostic test (x-ray, blood work)</td>
<td>After Plan deductible is met, No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>After Plan deductible is met, No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
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</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs (Tier 1)</td>
<td>Retail: $30 co-pay/30 day supply Mail Order: $75 co-pay/90 day supply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs (Tier 2)</td>
<td>After Plan deductible is met, Retail: No charge/30 day supply Mail Order: No charge/90 day supply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs (Tier 3)</td>
<td>After Plan deductible is met, Retail: No charge/30 day supply Mail Order: No charge/90 day supply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs (Tier 4)</td>
<td>Tier 1: $30 co-pay/30 day supply After Plan deductible is met, Tier 2 &amp; Tier 3: No charge/30 day supply</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>After Plan deductible is met, No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>After Plan deductible is met, No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>After Plan deductible is met, No charge</td>
<td>After Plan deductible is met, No charge</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>After Plan deductible is met, No charge</td>
<td>After Plan deductible is met, No charge</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$75 co-pay per visit</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>After Plan deductible is met, No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>After Plan deductible is met, No charge</td>
<td>Not covered</td>
</tr>
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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).
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</thead>
<tbody>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>After Plan deductible is met, No charge</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, No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td></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>If you are pregnant</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, No charge</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>After Plan deductible is met, No charge</td>
<td>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.</td>
</tr>
</tbody>
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<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></td>
<td></td>
<td>After Plan deductible is met, No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>After Plan deductible is met, No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>After Plan deductible is met, No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>After Plan deductible is met, No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>After Plan deductible is met, No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>After Plan deductible is met, No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>After Plan deductible is met, No charge</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).
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<tbody>
<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>If your child needs dental or eye care</strong></td>
<td>Children’s eye exam</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>$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:

**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
- Long-term care
- Most coverage provided outside the United States
- Non-emergency care when traveling outside the U.S.
- 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 plan document.)**

- Abortion services
- Acupuncture
- Bariatric surgery (Prior Approval required)
- Chiropractic care
- Dental care (Adult)
- Hearing aids (Prior Approval required)
- Infertility treatment (Prior Approval required)
- 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: New York State Department of Financial Services at 1-800-342-3736 or www.dfs.ny.gov, U.S. Department of Health and Human Services at 1-877-267-2323 x1565 or 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 or 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 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

**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

* For more information about limitations and exceptions, see the plan or policy document at www.emblemhealth.com/sbc.
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): Dine'ehgo shika at'ohwol ninisingo, kwiijigoh holne' 1-800-624-2414

To see examples of how this plan might cover costs for a sample medical situation, see the next section.
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)

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>$7,690</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Specialist</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Other</td>
<td>$60</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

This EXAMPLE event includes services like:
- Specialist office visits (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and blood work) Specialist visit (anesthesia)

**Total Example Cost** $12,800

In the example, Peg would pay:
- Deductibles: $7,350
- Copayments: $340
- Coinsurance: $0
- What isn't covered: Limits or exclusions: $60
- The total Peg would pay is $7,750

### Managing Joe’s type 2 diabetes
(a year of routine in-network care of a well-controlled condition)

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>$7,690</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Specialist</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Other</td>
<td>$55</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

This EXAMPLE event includes services like:
- Primary care physician office visits (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs
- Durable medical equipment (glucose meter)

**Total Example Cost** $7,400

In the example, Joe would pay:
- Deductibles: $6,374
- Copayments: $1,250
- Coinsurance: $0
- What isn't covered: Limits or exclusions: $55
- The total Joe would pay is $7,679

### Mia’s Simple Fracture
(in-network emergency room visit and follow up care)

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>$1,925</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Specialist</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Other</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

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** $1,900

In the example, Mia would pay:
- Deductibles: $1,925
- Copayments: $0
- Coinsurance: $0
- What isn't covered: Limits or exclusions: $0
- The total Mia would pay is $1,925

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.
Getting Help in a Language Other than English

ATTENTION: This is an important document. If you need help to understand it, please call the telephone number marked “customer service” on the back of your member ID card [TTY/TDD: 711]. We can give you an interpreter for free in the language you speak.

Español (Spanish)
ATENCIÓN: Este es un documento importante. Si necesita ayuda para entenderlo, llame al número telefónico marcado “customer service” que se encuentra en el dorso de su tarjeta de identificación de miembro [TTY/TDD: 711]. Le podemos proporcionar un intérprete que habla su idioma sin ningún costo.

tp (Traditional Chinese)
“customer service” TTY/TDD 711

PyccKMM (Russian)
BH1MAHV1E! 3TO BaKh2lI AOKyMeHT. ECnlt1 y BaC B03Hlt1 Knlt1 TpyAH0CTlt1 C nOHIlt1 MaHlt1 eM nTO7I0 AOKyMeHTa 2l BaM HeO6XOAlt1 Ma nOM0I1 b, nO3BOHIlt1 Te nO TenecpOHy OTAeHHy 06Chy-Knlt1 BaHlt1 s: Knlt1 eHTOB (customer service), yKa3aHHOMy Ha O6paTH0I1 CTOpOHe Bawel1 lt1 AeHTlt1 cplt1 KaLt1 OHOI1 KapTO4Klt1 [Cny>K6a TeKCTOBOrO TenecpOHa (TTY/TDD): 711]. Mb MO>KeM BeOnnaTIO npeAOCTaBl1 Tb BaM nepeBOA4lt1 Ka, KOTOPbl1 rOBOpl1 T Ha BaweM s:3bKe.

Kreyòl Ayisyen (Haitian Creole)
ATANSYON: Sa a se yon dokiman ki enpòtan. Si ou bezwen èd pou konprann li, tanpri rele nimewo ki make “customer service” nan do kat ID manm ou [TTY/TDD: 711]. Nou kapab ba ou yon entèprèt gratis nan lang ou pale a.

O (Korean)
.. ID “customer service” [TTY/TDD: 711]...

Italiano (Italian)
ATTENZIONE: Questo è un documento importante. Per qualsiasi chiarimento telefonì all “customer service” al numero stampato sul retro della Sua tessera (per i non udenti: 711). Possiamo mettere a disposizione gratis un interprete nella Sua lingua.

Yiddish
[TTY/TDD: 711] ‘7JINj7 IIJ”N C’IN “customer service” I9IIJ: IJJJ.nuJ I9J7IIJ 8’UT IJ9II IJJ”. I”UUIN9 I: OU C7”IJ IJ9IN’T I’N J.IN .IJJJUJ7I7NT IJ1IY”N N r”N ON’T :w”77Un .”UTUJ I’N ONII INIIU’ T I’N “19 IIJ::: IJIIJ.JN IN IJJLT I”N N IIIJ7 1’n
Polski (Polish)

UWAGA: To jest ważny dokument. Jeżeli potrzebujesz pomocy w celu zrozumienia jego treści, zadzwoń do „customer service” pod numer telefonu podany na odwrocie karty identyfikacyjnej ubezpieczonego (member ID card) [TTY/TDD: 711]. Możemy bezpłatnie zapewnić usługi tłumacza języka, którym się postulujesz.

Français (French)

ATTENTION : ce document est important. Si vous avez besoin d'aide pour en comprendre le contenu, veuillez composer le numéro «customer service » au dos de votre carte de membre [Sourds et malentendants : 711]. Nous pouvons mettre gratuitement à votre disposition un interprète dans votre langue.

Tagalog (Tagalog)

NANAWAGAN NG PANSIN: Ito ay isang mahalagang dokumento. Kung kailangan mo ng tulong para maintindihan ito, pakitawagan ang numero ng telepono na minarkahang “customer service” sa likod ng inyong ID card ng miyembro [TTY/TDD: 711]. Maaari ka naming bigyan ng libreng interpreter sa wikang iyong sinasalita.

EAArjVIKO (Greek)

nPOLOXH: AUTO T0 tυραρcρo εล’Wά oτ”μαVT]KΟ. EdV Χρε1δςξοΤΕ οες1a y1a Va To KaTaVoεςΣΕ, Kaf.toΤΕ μας oToV ap18μΟ TΤοU oτ”μάε1 ΙΕΤΑ1 ιc «customer service» oTo TΤIoW μπορος T”[c KdpTαc T”]c oUVόPους oac [ap18μΟc y1a dςoμα με TΤροςς. (μαTa αKΟς (TTY/TDD): 711]. MΤTόρωμής Va oac TΤροocπρομυους [ o1ερμ”]Vέfa oT”] μ”]ΤριΚΟ oac yf.Joaa.

Shqip (Albanian)

VINI RE: Ky është një dokument i rëndësishëm. Nëse ju nevojitet ndihmë për ta kuptuar, ju lutemi telefononi në numrin ku shkruhet “customer service”, i cili gjendet ne anen e pasë të kartës tuaj identifikuese të anëtarësisë [Shërbimi rele TTY/TDD: 711]. Ne mund t’ju ofrojmë pa pagesë një përkthyes në gjuhën që flisni ju.
NOTICE OF NONDISCRIMINATION POLICY

EmblemHealth complies with applicable 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 communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call the telephone number marked “customer service” on the back of your member ID card. 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 the telephone number marked “customer service” on the back of your member ID card. (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.