Coverage for: Individual/Family | Plan Type: PPO



Blue Cross® Premier PPO Silver Extra 94

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 1-888-288-2738 or go online to www.bcbsm.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other <u>underlined</u> terms, see the Glossary. You can view the Glossary at <u>www.healthcare.gov/sbc-glossary</u> or call 1-888-288-2738 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In- <u>network providers</u> , \$0 individual /\$0 family Out-of-network providers, \$0 individual /\$0 family	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your deductible?	Yes. All covered health services are covered without a <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 <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In- <u>network providers</u> , \$1,800 individual /\$3,600 family <u>Out-of-network providers</u> , \$3,600 individual /\$7,200 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See https://www.bcbsm.com/marketplace/ppo/ or call 1-888-288-2738 for a list of network providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan</u> 's <u>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</u> 's charge and what your <u>plan</u> 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.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

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

Common Medical	Medical Services You May What You Will Pay			
Event	Need Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care	Primary care/ Office & Virtual Retail health clinic/ 24/7 medical virtual visit to treat an injury or illness	No charge /primary care office and virtual visits, and retail health clinic visit. No charge 24/7 medical virtual visit.	45% <u>coinsurance</u>	Diagnostic and laboratory services are not included in the office visit copayment. These services are subject to the plan's coinsurance. No charge for 24/7 medical virtual visits when performed
provider's office or clinic	Specialist visit	\$10 copayment /visit	45% coinsurance	through the BCBSM selected vendor app.
	Preventive care/screening/ immunization	No charge	45% coinsurance	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
	Diagnostic test (x-ray, blood work)	25% coinsurance	45% coinsurance	None
If you have a test	Imaging (CT/PET scans, MRIs)	25% coinsurance	45% coinsurance	Prior authorization required. The penalty for not having prior authorization is denial of payment.
If you need drugs	Generic drugs	No charge	Not covered	
to treat your illness or condition More information about prescription drug coverage is available at https://www.bcbsm.com/2024-select-ppodruglist	Preferred brand drugs	Retail <u>copayment</u> per prescription: \$15 for 1-30 day supply \$45 for 84-90 day supply Mail order <u>copayment</u> per prescription: \$15 for 1-30 day supply \$30 for 31-60 day supply \$45 for 61-90 day supply <u>Deductible</u> does not apply.	Not covered	Opioid-containing medications are limited to no more than a 30-day supply per fill and first fills of select opioid containing medications will be limited to a 5-day supply. Prior authorization, step therapy and quantity limits may apply to select drugs. The penalty for not having prior authorization is denial of payment. Any coupon, rebate or other credits received directly or indirectly from the drug manufacturer may not be applied to a consumer's <u>deductible</u> , <u>cost-sharing</u> or <u>out of pocket maximum</u> . For <u>out-of-network providers</u> , member must pay the full cost of the drug and submit to BCBSM for reimbursement.

^{*} For more information about limitations and exceptions, see the plan or policy document at www.bcbsm.com/index/plans/michigan-health-insurance/2024.html

Common Medical	Services You May	What You Will Pay		
Event	Need Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition	Non-preferred brand drugs	Retail copayment per prescription: \$50 for 1-30 day supply \$150 for 84-90 day supply Mail order copayment per prescription: \$50 for 1-30 day supply \$100 for 31-60 day supply \$150 for 61-90 day supply Code code code code code code code code c	Not covered	Opioid-containing medications are limited to no more than a 30-day supply per fill and first fills of select opioid containing medications will be limited to a 5-day supply. Prior authorization, step therapy and quantity limits may apply to select drugs. The penalty for not having prior authorization is denial of payment. Any coupon, rebate or other credits received directly or indirectly from the drug manufacturer may not be applied to a consumer's deductible, cost-sharing or out of pocket maximum. For out-of-network providers, member must pay the full cost of the drug and submit to BCBSM for reimbursement.
More information about prescription drug coverage is available at https://www.bcbsm.com/2024-select-ppodruglist	Specialty drugs	Retail and mail order copay per prescription: \$150 for 1-30 day supply for Specialty drugs. Deductible does not apply.	Not covered	Specialty drugs are limited to a 30-day supply per fill, however some may be limited to a 15-day supply fill, depending on the medication. BCBSM has contracted with an exclusive pharmacy network for specialty drugs. Call the customer service phone number on the back of your ID card for the pharmacy's phone number or location nearest to you. If you obtain your specialty drugs from any other pharmacy, you are responsible for the total cost. Prior authorization, step therapy and quantity limits may apply to select drugs. The penalty for not having prior authorization is denial of payment. Any coupon, rebate or other credits received directly or indirectly from the drug manufacturer may not be applied to
If you have	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	45% coinsurance	a consumer's <u>deductible</u> , <u>cost-sharing</u> or <u>out of pocket maximum</u> . Excludes cosmetic surgery, corrective eye surgery, investigational and experimental procedures. These services may require prior authorization. The penalty for not
If you have outpatient surgery	Physician/surgeon fees	25% coinsurance	45% coinsurance	having prior authorization is denial of payment. 50% coinsurance for infertility, temporomandibular joint dysfunction (TMJ) and weight reduction procedures. Weight reduction procedures limited to one per lifetime.

^{*} For more information about limitations and exceptions, see the plan or policy document at www.bcbsm.com/index/plans/michigan-health-insurance/2024.html

Common Medical	Services You May	What You Will Pay			
Event	Need Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
If you need	Emergency room care	25% coinsurance	25% coinsurance	Emergency room visits will be covered at non-participating facilities for medical emergencies and accidental injuries only.	
immediate medical attention	Emergency medical transportation	25% coinsurance	25% coinsurance	Includes air and ground transportation. Excludes transportation for convenience.	
	Urgent care	\$5 copayment /visit	45% coinsurance	When the <u>urgent care</u> visit is for an emergency or accidental injury, <u>in-network cost sharing</u> applies.	
	Facility fee (e.g., hospital room)	25% coinsurance	45% coinsurance	BCBSM participating hospitals only. These services require prior authorization. The penalty for not having prior	
If you have a hospital stay	Physician/surgeon fees	25% <u>coinsurance</u>	45% coinsurance	authorization is denial of payment. 50% coinsurance for infertility, temporomandibular joint dysfunction (TMJ) and weight reduction procedures. Weight reduction procedures limited to one per lifetime.	
If you need mental health, behavioral	Outpatient services	No charge	45% coinsurance	<u>Copayment</u> applies to <u>provider</u> 's office, virtual visit by participating BCBSM <u>provider</u> and Blue Cross virtual care visit from BCBSM selected vendor app only. Additional services are subject to the <u>plan</u> 's <u>coinsurance</u> . BCBSM approved facilities only.	
health, or substance abuse services	Inpatient services	25% coinsurance	25% <u>coinsurance</u> for substance abuse 45% <u>coinsurance</u> for other inpatient services	BCBSM approved facilities only. These services require prior authorization. The penalty for not having prior authorization is denial of payment.	
If you are pregnant	Office visits	No charge	45% coinsurance	Cost sharing does not apply for preventive services with a network provider. Depending on the type of services, a copayment, or coinsurance, may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).	
1 0	Childbirth/delivery professional services	25% coinsurance	45% coinsurance	None	

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Common Medical Services You May What You Will Pay				
Event	Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you are pregnant	Childbirth/delivery facility services	25% coinsurance	45% coinsurance	BCBSM participating hospitals only. These services require prior authorization. The penalty for not having prior authorization is denial of payment.
	Home health care	25% coinsurance	25% coinsurance	BCBSM participating agencies only. Excludes housekeeping and custodial services.
	Rehabilitation services	No charge / physical, occupational & speech visits.	45% coinsurance	Plan's coinsurance will apply to chiropractic, osteopathic manipulative therapy and cardiac/pulmonary visits. Physical, occupational, chiropractic and osteopathic manipulative therapy limited to a combined maximum of 30 visits per member per calendar year. Speech therapy limited to a maximum of 30 visits per member per calendar year. Cardiac/pulmonary visits limited to a maximum of 30 visits per member per calendar year.
If you need help recovering or have other special health needs	Habilitation services	No charge	45% coinsurance	Physical and occupational therapy limited to a combined maximum of 30 visits per member per calendar year. Speech therapy limited to a maximum of 30 visits per member per calendar year.
	Skilled nursing care	25% coinsurance	45% coinsurance	Limited to a maximum of 45 days per member per calendar year. BCBSM participating facilities only. Excludes custodial care. These services require prior authorization. The penalty for not having prior authorization is denial of payment.
	Durable medical equipment	50% coinsurance	70% coinsurance	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription is required. Rental and purchase limited to basic equipment.
	Hospice services	No charge	No charge	Coverage includes inpatient and outpatient hospice care. BCBSM approved hospice programs only. Excludes housekeeping services.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Limited to once in a calendar year. A child is defined as a member up to the age of 19. <u>Out-of-network</u> is paid up to the <u>allowed amount</u> .

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Common Medical Services You May		What You Will Pay			
Event	Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
If your child needs dental or	Children's glasses	No charge	No charge	Frames (chosen from a select collection) and lenses are covered once in a calendar year. A child is defined as a member up to the age of 19. <u>Out-of-network</u> is paid up to the <u>allowed amount</u> .	
eye care	Children's dental check-up	Not covered	Not covered	Stand-alone dental <u>plans</u> available.	

^{*} For more information about limitations and exceptions, see the plan or policy document at www.bcbsm.com/index/plans/michigan-health-insurance/2024.html

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.)

- Abortion (except in the case of when the life of the mother is endangered). See section 5 in the plan's certificate.
- Hearing aids

Dental care (Adult)

Non-emergency care when traveling outside the U.S.

the <u>plan</u>'s certificate.Acupuncture

Long-term care

• Private-duty nursing

Cosmetic Surgery

Routine eye care (Adult)Routine foot care

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

Bariatric surgery

Chiropractic

- Infertility treatment
- · Weight loss programs

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: Michigan Department of Insurance and Financial Services at www.michigan.gov/difs at 1-877-999-6442. 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 <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: Michigan Department of Insurance and Financial Services at michigan.gov/difs at 1-877-999-6442.

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? Not Applicable

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 888-288-2738

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 888-288-2738

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码888-288-2738

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 888-288-2738

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

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^{*} For more information about limitations and exceptions, see the plan or policy document at www.bcbsm.com/index/plans/michigan-health-insurance/2024.html

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>	\$0
■ Specialist copayment	\$10
■ Hospital (facility) coinsurance	25%
Other coinsurance	25%

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	\$12,700	
In this example, Peg would pay:		
Cost Sharing		
<u>Deductibles</u>	\$0	
Copayments	\$0	
Coinsurance	\$1,800	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$1,860	

Managing Joe's Type 2 Diabetes

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

10
, , ,
5%
5%

This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (including disease education)

Diagnostic tests (blood work)

Prescription drugs

<u>Durable medical equipment</u> (glucose meter)

Total Example Cost	\$5,600
In this example, Joe would pay:	
Cost Sharing	
Deductibles	\$0
Copayments	\$20
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$240

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$0
Specialist copayment	\$10
■ Hospital (facility) coinsurance	25%
Other coinsurance	25%

This EXAMPLE event includes services like:

<u>Emergency room care</u> (including medical supplies)

Diagnostic test (x-ray)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$2,800
In this example, Mia would pay:	
Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$30
<u>Coinsurance</u>	\$600
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$630

The <u>plan</u> would be responsible for the other costs of these EXAMPLE covered services.

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We speak your language

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta, o 877-469-2583, TTY: 711 si usted todavía no es un miembro.

إذا كنت أنت أو شخص آخر تساعده بحاجة لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم -469-877 2713

如果您,或是您正在協助的對象,需要協助,您有權利免費以您的母語得到幫助和訊息。要洽詢一位翻譯員,請撥在您的卡背面的客戶服務電話:如果您還不是會員,請撥電話 877-469-2583, TTY: 711。

کی بخسلان کی نے بنہ فتی دقعہ دفیصلان کی بخسلان کی بخسلا

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị, hoặc 877-469-2583, TTY: 711 nếu quý vị chưa phải là một thành viên.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj, ose 877-469-2583, TTY: 711 nëse nuk jeni ende një anëtar.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하거나, 이미 회원이 아닌 경우 877-469-2583, TTY: 711로 전화하십시오.

যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায়তা নম্বরে কল করুন বা 877-469-2583, TTY: 711 যদি ইতোমধ্যে আপনি সদস্য না হয়ে থাকেন।
Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy,

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty lub pod numer 877-469-2583, TTY: 711, jeżeli jeszcze nie masz członkostwa.

Falls Sie oder jemand, dem Sie helfen, Unterstützung

benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an oder 877-469-2583, TTY: 711, wenn Sie noch kein Mitglied sind. Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda o chiama il 877-469-2583, TTY: 711 se non

ご本人様、またはお客様の身の回りの方で支援を必要とされる方で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はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号(メンバーでない方は877-469-2583, TTY: 711) までお電話ください。

sei ancora membro.

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по номеру телефона отдела обслуживания клиентов, указанному на обратной стороне вашей карты, или по номеру

877-469-2583, ТТҮ: 711, если у вас нет членства.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na svom jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice ili 877-469-2583, TTY: 711 ako već niste član.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta, o 877-469-2583, TTY: 711 kung ikaw ay hindi pa isang miyembro.

Important disclosure

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Office of Civil Rights Coordinator,

600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226, phone: 888-605-6461, TTY: 711, fax: 866-559-0578, email: CivilRights@bcbsm.com. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health & 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, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 800-368-1019, TTD: 800-537-7697, email: OCRComplaint@hhs.gov. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.htm

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