



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 1-888-227-2345 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 underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-888-288-2738 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$3,500 Individual/\$7,000 Family	Generally, you must pay all of the costs from providers 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. <u>Preventive care</u> , primary care visits, lab, and <u>urgent care</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 <u>deductibles</u> for specific services?	Yes. <u>Specialty drugs</u> - \$500 Individual/\$1,000 Family	You must pay all of the cost for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$7,350 Individual/\$14,700 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 <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing charges</u> , and health care this <u>plan</u> 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 http://www.bcbsm.com/index/common/marketplace/select-hmo.html or call 1-888-227-2345 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan'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 provider's charge and what your <u>plan</u> pays (<u>balance billing</u>).
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes	This <u>plan</u> will pay some or all of the costs to see a specialist for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit/Online Visit to treat an injury or illness	\$30/visit <u>Deductible</u> does not apply	Not covered	None.
	<u>Specialist</u> visit	\$65/visit <u>Deductible</u> does not apply 20% <u>coinsurance</u> for allergy testing 20% <u>coinsurance</u> for spinal manipulations	Not covered	<u>Referral</u> Required. The penalty for not having a <u>referral</u> is denial of payment. Spinal manipulations limited to 30 visits per member per calendar year.
	<u>Preventive care/screening/immunization</u>	No charge <u>Deductible</u> does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive; then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	Not covered	May require prior authorization. The penalty for not having prior authorization is denial of payment.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	Not covered	Prior authorization required. The penalty for not having prior authorization is denial of payment.

*For more information about limitations and exception, see plan or policy document at <http://www.bcbsm.com/index/plans/michigan-health-insurance/2018.html>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information	
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)		
<p>If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at http://www.bcbsm.com/2018selectdruglist</p>	Tier 1-Generic drugs	\$15/prescription-Retail & mail order 30-day supply. <u>Deductible</u> does not apply	Not covered	<p>May require prior authorization & Step Therapy. The penalty for not having prior authorization is denial of payment. No charge for Tier 1 contraceptives. Drugs for the treatment of sexual dysfunction, weight loss, cough & cold, infertility, and compounds are not covered.</p>	
		\$45/prescription-Retail 84-90-day supply & mail order 31-90-day supply. <u>Deductible</u> does not apply			
	Tier 2-Preferred brand drugs	\$50/prescription-Retail & mail order 30-day supply. <u>Deductible</u> does not apply	Not covered		
		\$150/prescription-Retail 84-90-day supply & mail order 31-90-day supply. <u>Deductible</u> does not apply			
	Tier 3-Non-preferred brand drugs	\$100/prescription-Retail & mail order 30-day supply. <u>Deductible</u> does not apply	Not covered		
		\$300/prescription-Retail 84-90-day supply & mail order 31-90-day supply. <u>Deductible</u> does not apply			
	Tier 4- <u>Specialty drugs</u>	40% <u>coinsurance</u>	Not covered		<p>May require prior authorization & Step Therapy. The penalty for not having prior authorization is denial of payment. <u>Specialty drugs</u> are limited to a 15 or 30-day supply.</p>

*For more information about limitations and exception, see plan or policy document at <http://www.bcbsm.com/index/plans/michigan-health-insurance/2018.html>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u> 50% <u>coinsurance</u> for infertility services	Not covered	May require prior authorization & Step Therapy. The penalty for not having prior authorization is denial of payment. Female sterilization covered in full. *See section 8
	Physician/surgeon fees	50% <u>coinsurance</u> TMJ procedures 50% <u>coinsurance</u> weight reduction procedures		
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Accidental injuries and medical emergencies only.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Includes air and ground transportation. Services provided by an emergency responder that does not provide transportation and transportation for convenience are excluded.
	<u>Urgent care/Retail health center visit</u>	\$75/visit <u>Deductible</u> does not apply	\$75/visit <u>Deductible</u> does not apply	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u> 50% <u>coinsurance</u> for infertility services	Not covered	Prior authorization required. The penalty for not having prior authorization is denial of payment. Female sterilization covered in full. *See section 8
	Physician/surgeon fees	50% <u>coinsurance</u> TMJ procedures 50% <u>coinsurance</u> weight reduction procedures		

*For more information about limitations and exception, see plan or policy document at <http://www.bcbsm.com/index/plans/michigan-health-insurance/2018.html>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <u>copay</u> /office and online visit <u>Deductible</u> does not apply 20% <u>coinsurance</u> for other outpatient services	Not covered	Prior authorization is not required for outpatient, office and online visits. Prior authorization is required for other outpatient services. The penalty for not having prior authorization is denial of payment. *See section 8
	Inpatient services	20% <u>coinsurance</u>	Not covered	Prior authorization is required for inpatient services. The penalty for not having prior authorization is denial of payment. *See section 8
If you are pregnant	Office visits	No charge for prenatal visit. <u>Deductible</u> does not apply. \$30/postnatal visit. <u>Deductible</u> does not apply.	Not covered	None.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	Not covered	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	Not covered	Housekeeping services and custodial care are excluded.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	Not covered	Prior authorization required. The penalty for not having prior authorization is denial of payment. PT & OT limited to a combined 30 visits per member per calendar year. Speech Therapy limited to 30 visits per member per calendar year. *See section 8
	<u>Habilitation services</u>	20% <u>coinsurance</u>	Not covered	Prior authorization required. The penalty for not having prior authorization is denial of payment. PT & OT limited to a combined 30 visits per member per calendar year. Speech Therapy limited to 30 visits per member per calendar year. *See section 8

*For more information about limitations and exception, see plan or policy document at <http://www.bcbsm.com/index/plans/michigan-health-insurance/2018.html>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	Not covered	Prior authorization required. The penalty for not having prior authorization is denial of payment. Limited to 45 days per calendar year. Custodial care is excluded.
	<u>Durable medical equipment</u>	50% <u>coinsurance</u> 20% <u>coinsurance</u> for diabetic testing supplies	Not covered	Prior authorization required. The penalty for not having prior authorization is denial of payment. Breast pumps are covered in full when preauthorized. *See section 8
	<u>Hospice services</u>	No charge	Not covered	Prior authorization required. The penalty for not having prior authorization is denial of payment. BCN participating hospice programs only. *See section 8
If your child needs dental or eye care	Children's eye exam	No charge. <u>Deductible</u> does not apply.	Difference between the BCN approved amount and the amount charged by the <u>provider</u>	Limited to once per calendar year through the last day of the year in which the individual turns 19.
	Children's glasses	No charge. <u>Deductible</u> does not apply.	Difference between the BCN approved amount and the amount charged by the <u>provider</u>	
	Children's dental check-up	Not covered	Not covered	Stand-alone dental plans available.

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.)

- | | | |
|--|---|---|
| <ul style="list-style-type: none"> • Abortion (except in cases of rape, incest or when the life of the mother is endangered) • Acupuncture • Artificial Insemination and In-Vitro Fertilization | <ul style="list-style-type: none"> • Cosmetic surgery • Dental care (adult) • Hearing aids • Long-term care | <ul style="list-style-type: none"> • Non-emergency care when traveling outside the US • Private-duty nursing • Routine eye care (adult) • Routine foot care |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- | | | |
|--|---|--|
| <ul style="list-style-type: none"> • Bariatric Surgery • Chiropractic Care | <ul style="list-style-type: none"> • Infertility treatment | <ul style="list-style-type: none"> • Weight loss programs |
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*For more information about limitations and exception, see plan or policy document at <http://www.bcbsm.com/index/plans/michigan-health-insurance/2018.html>

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/ebsa/contactEBSA/consumerassistance.html>, or Michigan Department of Insurance and Financial Services at michigan.gov/difs or 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 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 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 Care Network, Appeals and Grievance Unit, MC C248, P.O. Box 248, Southfield, MI 48086 or fax 888-458-0716. For State of Michigan assistance contact the Michigan Department of Insurance and Financial Services, Healthcare Appeals Section, Office of General Council, 611 W. Ottawa St, 3rd Floor, Lansing, MI 48909-7720, michigan.gov/difs or 1-877-999-6442.

Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP), at 877-999-6442 or DIFS-HICAP@Michigan.gov.

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 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, kwijigo holne' 888-288-2738.]

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$3,500
■ <u>Specialist copayment</u>	\$65
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,500
Copayments	\$100
Coinsurance	\$2,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$6,160

Managing Joe's type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$3,500
■ <u>Specialist copayment</u>	\$65
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$1,500
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$3,460

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$3,500
■ <u>Specialist copayment</u>	\$65
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1300
Copayments	\$200
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,800

The plan would be responsible for the other costs of these EXAMPLE covered services.

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 تساعد به حاجة لمساعدة، فليك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم 877-469-2583، إذا لم تكن مشتركاً بالفعل.

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。

كيسلقة، ني نيد فيني فقه على مساعده لمساعدة، فليك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم 877-469-2583، إذا لم تكن مشتركاً بالفعل.

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 আপনাকে বা আপনাকে সাহায্য করছেন এমন কারো সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দো-ভাষীর সাথে কথা বলতে, আপনার কার্ডের পিছনে 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, potrzebujesz pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy w 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 sei ancora membro.

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、情報を入力したりすることができません。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。

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, TTY: 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.html>.