

Rankin Audiology & Hearing

A nonprofit corporation and independent licenses of the Blue Cross and Blue Shield Association

2025 BCN Gold Option 3 W/Expanded Abortion

Coverage for: All Contract Types | Plan Type: HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbsm.com or call (800) 662-6667. 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 (https://www.healthcare.gov/sbc-glossary) or call (800) 662-6667 to request a copy.

Important Questions	Answers: Member / Family	Why This Matters:
What is the overall <u>deductible</u> ?	\$1,500/\$3,000	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes Lab, <u>preventive care</u> , <u>DME/P&O</u> , diabetic supplies, <u>PCP</u> office visits, <u>specialist</u> office visits, <u>urgent care</u> , allergy injections, <u>prescription drugs</u> , outpatient mental health and substance use services	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</u> <u>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?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$8,150/\$16,300 <u>Coinsurance</u> Maximum - \$2,500/\$5,000	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 billed 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 (<u>www.BCBSM.com</u>) or call customer service for a list of <u>network providers</u> and out-of-state coverage. (800) 662-6667	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's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider</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> ?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</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.

		What You	Will Pay			
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information		
	Primary care visit to treat an injury or illness	\$20 <u>copay</u> /visit. <u>Deductible</u> does not apply	Not covered	Only the <u>PCP</u> office visit is exempt from the <u>deductible</u> . Other services received in the office, <u>deductible</u> applies. \$0 <u>copay</u> for medical online visits.		
If you visit a health care provider's office or clin		\$40 <u>copay</u> /visit. <u>Deductible</u> does not apply	Not covered	Requires referral. \$5 copay for allergy injections/50% coinsurance for allergy office visit and testing /30 combined visits for spinal manipulations performed by a chiropractor or osteopathic physician Deductible applies for allergy testing		
	Preventive care/screening/immunization	No charge. <u>Deductible</u> does not apply	Not covered	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.		
If you have a test	Diagnostic test (x-ray, blood work)	20% <u>coinsurance</u> .	Not covered	May require <u>preauthorization</u> / No charge for lab services <u>Deductible</u> does not apply to lab services.		
	Imaging (CT/PET scans, MRIs)	\$150 <u>copay</u>	Not covered	Requires <u>preauthorization</u>		

		What You	Will Pay			
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information		
	Preferred Generic Tier	\$10 <u>copay</u> /30 days. <u>Deductible</u> does not apply	Not covered	Prior-auth & step therapy may apply. Drugs for sexual dysfunction, weight loss, cough & cold		
	Non-Preferred Generic Tier	\$30 <u>copay</u> /30 days. <u>Deductible</u> does not apply	Not covered	and compounds are excluded. No charge for Preferred Generic contraceptives and		
If you would always to tweet	Preferred Brand Tier	\$60 <u>copay</u> /30 days. <u>Deductible</u> does not apply	Not covered	preventive drugs. 84-90 day retail & 31-90 day mail order copays are 3x the 30-day copay minus \$10. Your plan includes a prescription		
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bcbsm.com/csdl25	Non-Preferred Brand Tier	\$80 <u>copay</u> /30 days. <u>Deductible</u> does not apply		drug discount program for certain medications. When a manufacturer coupon is used through the BCN discount program, the amount paid after the discount applies toward the out of pocket maximum.		
	Preferred <u>Specialty</u> Tier	20% <u>coinsurance</u> . <u>Deductible</u> does not apply	Not covered	\$200 <u>copay</u> max. <u>Specialty drugs</u> are covered only when obtained from the BCN Exclusive <u>Specialty</u> Pharmacy <u>Network</u> . Limited to a 30 day supply.		
	Non-Preferred <u>Specialty</u> Tier	20% <u>coinsurance</u> . <u>Deductible</u> does not apply	Not covered	\$300 <u>copay</u> max. See Preferred <u>Specialty</u> Tier for <u>network</u> and day supply limits. Limited to a 30 day supply.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	May require <u>preauthorization</u> /50% <u>coinsurance</u> for weight reduction procedures,TMJ, orthognathic surgery, reduction mammoplasty, male mastectomy, elective abortion		
	Physician/surgeon fees	20% coinsurance	Not covered	See "Outpatient surgery facility fee"		
	Emergency room care	\$250 <u>copay</u> /visit.	\$250 <u>copay</u> /visit.	Copay waived if admitted as inpatient.		
If you need immediate medical attention	Emergency medical transportation	20% coinsurance	20% coinsurance	Non-emergent transport is covered when preauthorized		
	<u>Urgent care</u>	\$50 <u>copay</u> /visit. <u>Deductible</u> does not apply	\$50 <u>copay</u> /visit. <u>Deductible</u> does not apply	None		

		What You	Will Pay		
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	Preauthorization is required. 50% coinsurance for weight reduction procedures, TMJ, orthognathic surgery, reduction mammoplasty, male mastectomy, elective abortion	
	Physician/surgeon fee	No charge	Not covered	See "Hospital stay facility fee"	
If you need behavioral health services (mental	Outpatient services	\$20 <u>copay</u> /visit. <u>Deductible</u> does not apply	Not covered	May require <u>preauthorization</u> .	
health and substance use disorder)	Inpatient services	20% coinsurance	Not covered	Preauthorization is required.	
If you are pregnant	Office visits	No charge. <u>Deductible</u> does not apply	Not covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) and depending on the type of services, cost share may apply. Office visit copay applies to non-routine prenatal and postnatal office visits Only the routine prenatal and postnatal visit is exempt from the deductible. Other services, deductible applies	
	Childbirth/delivery professional services	No charge	Not covered	None	
	Childbirth/delivery facility services	20% coinsurance	Not covered	None	

		What You	ı Will Pay		
Common Medical Event	Services You May Need	ices You May Need Network Provider (You will pay the least)		Limitations, Exceptions, & Other Important Information	
	Home health care	\$40 <u>copay</u> /visit	Not covered	None	
If you need help recovering or have other	Rehabilitation services	\$40 <u>copay</u> /visit	Not covered	Requires <u>preauthorization</u> /limited to 30 visits per calendar year for PT/OT combined/30 visits per calendar year for speech therapy./30 visits per calendar year for pulmonary/cardiac.	
	Habilitation services	ABA - \$20 copay per visit. \$40 copay per visit for PT/OT/ST. Deductible does not apply to ABA services	Not covered	Requires <u>preauthorization</u> /limited to 30 visits per calendar year for PT/OT combined. 30 visits per calendar year for speech therapy.	
special health needs	Skilled nursing care	20% coinsurance	Not covered	Requires <u>preauthorization</u> /Limited to 45 days per calendar year	
	Durable medical equipment	50% <u>coinsurance</u> . <u>Deductible</u> does not apply	Not covered	Must be authorized and obtained from a BCN supplier. Certain diabetic supplies are covered through the pharmacy benefit. Applicable pharmacy cost-sharing will apply. <u>Deductible</u> does not apply to diabetic supplies	
	Hospice services	No charge	Not covered	Inpatient care requires preauthorization	
	Children's eye exam	No Charge	Difference between approved amount and provider's charge.	Limited to once/calendar year through the last day of the year in which the individual turns age 19	
dental or eye care	Children's glasses	No Charge	Difference between approved amount and provider's charge.	Frames and lenses covered once/calendar year through the last day of the year in which the individual turns age 19.	
	Children's dental check-up	Contact your benefit administrator for coverage information.	Not Covered	Contact your benefit administrator for coverage information.	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental Care (Adult)
- Hearing aids

- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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.)

- Bariatric surgery (Limited to one per lifetime.
 Requires preauthorization)
- Chiropractic care

 Infertility treatment (Coverage includes diagnosis/counseling/treatment of infertility when medically necessary and preauthorized by BCN. See Certificate of Coverage for exclusions)

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform., or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your <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 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: Blue Care Network, Appeals and Grievance Unit, MC C248, P.O. Box 284, Southfield, MI 48086 or fax. 1-866-522-7345. For state of Michigan assistance contact the Department of Insurance and Financial Services, Office of General Counsel-Appeals Section, 530 W. Allegan Street, 7th Floor, P. O. Box 30220, Lansing, MI 48909-7720, http://www.michigan.gov/difs; call 1-877-999-6442 or fax: 517-284-8838.

For Department of Labor assistance contact the Employee Benefits Security Administration at 1-866-444- EBSA (3272) or www.dol.gov/ebsa/healthreform

Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP), Department of Insurance and Financial Services, P. O. Box 30220, Lansing, MI 48909-7720, http://www.michigan.gov/difs or difs-HICAP@michigan.gov

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 Standard? Yes

If your <u>plan</u> doesn't meet the <u>Minimum Value Standards</u>, you may be eligible for a <u>premium tax credit</u> to help you pay for a <u>plan</u> through the <u>Marketplace</u>. (IMPORTANT: Blue Care Network of Michigan is assuming that your coverage provides for all Essential Health Benefits (EHB) categories as defined by the State of Michigan. The minimum value of your <u>plan</u> may be affected if your <u>plan</u> does not cover certain EHB categories, such as <u>prescription drugs</u>, or if your <u>plan</u> provides coverage for specific EHB categories, for example, <u>prescription drugs</u>, through another carrier.)

Translation available

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To see exan	nples of how this plan might cove	r costs for a sample medical situation	n, see the next page.	

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 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>	\$1500
■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:

Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

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

Cost Sharing				
<u>Deductibles</u>	\$1,500			
<u>Copayments</u>	\$10			
<u>Coinsurance</u>	\$1,400			
What isn't covered				
Limits or exclusions	\$60			
The total Peg would pay is \$2,97				

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$1500
■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

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

Diagnostic tests (blood work)

Prescription drugs

Durable medical equipment (glucose meter)

Total Example Cost	\$5,600

In this example, Joe would pay:

<u>Cost Sharing</u>		
<u>Deductibles</u>	\$0	
<u>Copayments</u>	\$1,100	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$1,120	

Mia's Simple Fracture

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

■ The plan's overall deductible	\$1500
■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic tests (x-ray)

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

Rehabilitation services (physical therapy)

Total Example Cost	\$2,800

In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$200
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900

If you are also covered by an account-type <u>plan</u> such as an integrated health reimbursement arrangement (HRA), and/or an health savings account (HSA), then you may have access to additional funds to help cover certain <u>out-of-pocket expenses-like deductible</u>, <u>copayments</u>, or <u>coinsurance</u> or benefits not otherwise covered.

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

ADDENDUM – LANGUAGE ACCESS SERVICES and NON-DISCRIMINATION

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 بلختك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم TTY:711 و872-469-877، إذا لم تكن مشتركا 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。

Nếu quý vị, hay người mà quý vị đang giúp đổ, 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 비용부담 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 আগনার, বা আগনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আগনার ভাষায় বিনামূল্যে সাহায্য ও তখ্য পাওয়ার অধিকার আগনার রয়েছে। কোনো একজন দোভাষীর সাথে কখা বলতে, আগনার কার্ডের পেছনে দেওয়া গ্লাহক 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, 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 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。

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.