WESTERN MICHIGAN UNIVERSITY

Community Blue PPOSM ASC

Coverage Period: Beginning on or after 01/01/2023

Coverage for: Individual/Family | Plan Type: PPO

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 the number on the back of your BCBSM ID card. For general definitions of common terms, such as allowed amount, <a href="mailto:bolder: bolder: bolde

	Answers				
Important Questions	In-Network		Out-of-Network	Why this Matters:	
	Level 1	Level 2	Out-or-Network		
What is the overall <u>deductible</u> ?	\$450 Individual/ \$900 Family	\$900 Individual/ \$1,800 Family	\$1,800 Individual/ \$3,600 Family	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. <u>Preventive care</u> services are covered before you meet your <u>deductible</u> .		e covered before	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?	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> ? (May include a <u>coinsurance</u> maximum)	\$2,000 Individual/ \$4,000 Family \$8,000 Family		1	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 limits</u> has been met.	
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billing charges, any pharmacy penalty and health care this plan doesn't cover.			Even though you pay these expenses, they don't count toward the <u>out–of–pocket</u> <u>limit</u> .	
Will you pay less if you use a network provider?	Yes. See www.bcbsm.com or call the number on the back of your BCBSM ID card for a list of network providers .			You pay the least if you use a <u>provider</u> in Level 1. You pay more if you use a <u>provider</u> in Level 2. 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's</u> 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 specialist you choose without a referral.	



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

			What You Will Pay		
II OMMON WAGICALEVANT	Services You May Need	In-Network Provider		Out-of-Network	Limitations, Exceptions, & Other
		Level 1 (You will pay the least)	Level 2 (You will pay more)	Provider (You will pay the most)	Important Information
	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /office visit; <u>deductible</u> does not apply	\$25 <u>copay</u> /office visit; <u>deductible</u> does not apply	30% coinsurance	None
If you visit a health care provider's office or	Specialist visit	\$40 <u>copay</u> /visit; <u>deductible</u> does not apply	\$40 <u>copay</u> /visit; <u>deductible</u> does not apply	30% coinsurance	None
clinic	Preventive care/ screening/ immunization	No Charge; <u>deductible</u> does not apply	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	<u>Diagnostic test</u> (x-ray, blood work)	10% coinsurance	10% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	10% coinsurance	30% coinsurance	May require preauthorization
If you need drugs to treat your illness or condition More information about	Generic drugs	\$10 copay/prescription for retail 30-day supply; \$25 copay/prescription for retail 90-day supply; \$20 copay/prescription for mail order 90-day supply deductible does not apply	\$10 copay/prescription for retail 30-day supply; \$25 copay/prescription for retail 90-day supply; \$20 copay/prescription for mail order 90-day supply deductible does not apply	In-Network <u>copay</u> plus an additional 25% of the approved amount; <u>deductible</u> does not apply	Preauthorization, step therapy and quantity limits may apply to select drugs. Preventive drugs covered in full. 90-day supply not
prescription drug coverage is available at www.bcbsm.com/druglists	Preferred brand- name drugs	\$40 copay/prescription for retail 30-day supply; \$100 copay/prescription for retail 90-day supply; \$80 copay/prescription for mail order 90-day supply; deductible does not apply	\$40 copay/prescription for retail 30-day supply; \$100 copay/prescription for retail 90-day supply; \$80 copay/prescription for mail order 90-day supply; deductible does not apply	In-Network <u>copay</u> plus an additional 25% of the approved amount; <u>deductible</u> does not apply	covered out of network. Select diabetic supplies and devices may be covered under the prescription drug program.

			What You Will Pay		
	Services You May Need	In-Networ	k Provider	Out-of-Network	Limitations, Exceptions, & Other Important Information
Common Medical Event		Level 1 (You will pay the least)	Level 2 (You will pay more)	Provider (You will pay the most)	
	Nonpreferred brand- name drugs	\$80 copay/prescription for retail 30-day supply; \$200 copay/prescription for retail 90-day supply; \$160 copay/prescription for mail order 90-day supply; deductible does not apply	\$80 copay/prescription for retail 30-day supply; \$200 copay/prescription for retail 90-day supply; \$160 copay/prescription for mail order 90-day supply; deductible does not apply	In-Network <u>copay</u> plus an additional 25% of the approved amount; <u>deductible</u> does not apply	
	Generic and preferred brand-name specialty drugs	copay/prescription for retail	15% coinsurance of the approved amount, but no more than \$150 copay/prescription for retail or mail order 30-day supply; deductible does not apply	In-Network <u>copay</u> plus an additional 25% of the approved amount; <u>deductible</u> does not apply	Preauthorization is required. Specialty drugs limited to a 15 or 30-day supply. Pharmacy Specialty drugs obtained from other than an
	Nonpreferred brand- name specialty drugs	25% coinsurance of the approved amount, but no more than \$300 copay/prescription for retail or mail order 30-day supply; deductible does not apply	25% coinsurance of the approved amount, but no more than \$300 copay/prescription for retail or mail order 30-day supply; deductible does not apply	In-Network <u>copay</u> plus an additional 25% of the approved amount; <u>deductible</u> does not apply	Exclusive Specialty Pharmacy Network provider will not be covered.
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	10% coinsurance	30% coinsurance	None
surgery	Physician/surgeon fees	10% coinsurance	10% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	\$150 copay/visit; deductible does not apply	\$150 copay/visit; deductible does not apply	\$150 <u>copay</u> /visit; <u>deductible</u> does not apply	Copay waived if admitted or for an accidental injury.
	Emergency medical transportation	10% coinsurance	10% coinsurance	10% coinsurance	Mileage limits apply
	Urgent care	\$40 <u>copay</u> /visit; <u>deductible</u> does not apply	\$40 <u>copay</u> /visit; <u>deductible</u> does not apply	30% coinsurance	None

			What You Will Pay		
Common Medical Event	Services You May Need	In-Networ	k Provider	Out-of-Network	Limitations, Exceptions, & Other Important Information
Common Medical Event		Level 1 (You will pay the least)	Level 2 (You will pay more)	Provider (You will pay the most)	
If you have a hospital	Facility fee (e.g., hospital room)	10% coinsurance	10% coinsurance	30% coinsurance	Preauthorization is required
stay	Physician/surgeon fee	10% coinsurance	10% coinsurance	30% coinsurance	None
If you need behavioral health services (mental health and substance use disorder)	Outpatient services	10% coinsurance	10% coinsurance	10% coinsurance for mental health; 30% coinsurance for substance use disorder	Your cost share may be different for services performed in an office setting
	Inpatient services	10% coinsurance	10% coinsurance	30% coinsurance	Preauthorization is required.
	Office visits	Prenatal: No Charge; deductible does not apply Postnatal: No Charge; deductible does not apply	Prenatal: No Charge; deductible does not apply Postnatal: No Charge; deductible does not apply	Prenatal: 30% coinsurance Postnatal: 30% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) and depending on the type of services <u>cost share</u> may apply. <u>Cost sharing</u> does not apply for <u>preventive services</u> .
If you are pregnant	Childbirth/delivery professional services	10% coinsurance	10% coinsurance	30% coinsurance	None
	Childbirth/delivery facility services	10% coinsurance	10% coinsurance	30% coinsurance	None
	Home health care	10% coinsurance	10% coinsurance	10% coinsurance	Physician certification required.
If you need help recovering or have other special health needs	Rehabilitation services	10% coinsurance	10% coinsurance	30% coinsurance	Physical, Speech and Occupational Therapy is limited to a combined maximum of 60 visits per member, per calendar year.
	Habilitation services	Not covered for Applied Behavior Analysis; Not covered for Physical, Speech and Occupational Therapy	10% <u>coinsurance</u> for Applied Behavior Analysis; 10% <u>coinsurance</u> for Physical, Speech and Occupational Therapy	10% <u>coinsurance</u> for Applied Behavior Analysis; 30% <u>coinsurance</u> for Physical, Speech and Occupational Therapy	Applied behavior analysis (ABA) treatment for Autism - when rendered by an approved licensed behavior analyst - subject to preauthorization.

			What You Will Pay		
Common Medical Event	Services You May Need	In-Networ	k Provider	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
		Level 1 (You will pay the least)	Level 2 (You will pay more)		
	Skilled nursing care	10% coinsurance	10% coinsurance	10% coinsurance	<u>Preauthorization</u> is required. Limited to 120 days per member per calendar year
	Durable medical equipment	10% coinsurance	10% coinsurance	10% coinsurance	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	Hospice services	No Charge; <u>deductible</u> does not apply	not apply	No Charge; deductible does not apply	Physician certification required. Visit limits apply.
If your child needs	Children's eye exam	Not covered	Not covered	Not covered	None
conjaci vojir bjan	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	Not covered	None

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 treatment	 Infertility treatment 	Weight loss programs		
Cosmetic surgery	 Long term care 			
Hearing aids	 Routine foot care 			

Hearing aids	Routine foot care	
Other Covered Services (Limitations may apply to	o these services. This isn't a complete	list. Please see your <u>plan</u> document.)
Bariatric surgery	Dental care (Adult)	Routine eye care (Adult)
Chiropractic care	Non-emergency care when traveli	ng outside the
Coverage provided outside the United States. See http://provider.bcbs.com.	U.S • Private-duty nursing	

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 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov or by calling the number on the back of your BCBSM ID card. 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 Cross[®] and Blue Shield[®] of Michigan by calling the number on the back of your BCBSM ID card.

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 or 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 Minimum Value Standards? Yes

Language Access Services: See Addendum

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 Cross Blue Shield of Michigan is assuming that your coverage provides for all Essential Health Benefit (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 of specific EHB categories, for example <u>prescription drugs</u>, through another carrier.)

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>	\$450
■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

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>	\$450		
<u>Copayments</u>	\$10		
Coinsurance	\$1,000		
What isn't covered			
Limits or exclusions	\$60		
The total Peg would pay is	\$1,520		

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>	\$450
■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:

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

<u>Diagnostic tests</u> (blood work)

Prescription drugs

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

In this example, Joe would pay:

Cost Sharing		
<u>Deductibles</u>	\$450	
Copayments	\$800	
Coinsurance	\$50	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$1,320	

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$450
■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

This EXAMPLE event includes services like:

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

<u>Diagnostic tests</u> (*x-ray*)

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

Rehabilitation services (physical therapy)

Total Example Cost	\$2,800
--------------------	---------

In this example, Mia would pay:

m and example, ma weara pay.		
Cost Sharing		
<u>Deductibles</u>	\$450	
Copayments	\$90	
Coinsurance	\$100	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$640	

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

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 بلغتك 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 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 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, ভাহলে আগনার ভাষায় বিনামূল্যে সাহায্য ও ভখ্য পাওয়ার অধিকার আগনার রয়েছে। কোনো একজন দোভাষীর সাথে কখা বলভে, আগনার কার্ডের পেছনে দেওয়া গ্রাহক সহায়ভা নম্বরে কল করুন বা ৪77-469-2583, TTY: 711 যদি ইভোমধ্যে আগনি 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.