**Expanded Bronze Off Exchange Plan** 

Coverage for: Individual/Family | Plan Type: PPO

Coverage Period: 01/01/2022 – 12/31/2022

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 <a href="https://ambetterofoklahoma.com/2022-brochures.html">https://ambetterofoklahoma.com/2022-brochures.html</a>, or call 1-833-492-0679 (TTY 711). For general definitions of common terms, such as <a href="mailto:allowed amount">allowed amount</a>, <a href="mailto:belling">belling</a>, <a href="mailto:coinsurance">coinsurance</a>, <a href="mailto:coinsurance">copayment</a>, <a href="mailto:deductible">deductible</a>, <a href="mailto:provider">provider</a>, or other <a href="mailto:underlined">underlined</a> terms, see the Glossary. You can view the Glossary at <a href="https://www.healthcare.gov/sbc-qlossary">https://www.healthcare.gov/sbc-qlossary</a> or call 1-833-492-0679 (TTY 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network providers: \$8,300 Individual / \$16,600 Family. Out-of-network providers: \$20,000 Individual / \$40,000 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 deductible?	Yes. Preventive care services, urgent care office visits, children's eye exam and glasses and generic drugs are covered before you meet your deductible.	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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
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> ?	For network providers: \$8,700 Individual / \$17,400 Family. For out-of-network providers: Not applicable Individual / Not applicable 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 out-of-pocket limit.
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="https://ambetterofoklahoma.com/findadoc">https://ambetterofoklahoma.com/findadoc</a> or call 1-833-492-0679 (TTY 711) for a list of <a href="network">network</a> <a href="providers">providers</a> .	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'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.

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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		What Yo	u Will Pay	Limitations, Exceptions, & Other
Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information
	Primary care visit to treat an injury or illness	\$40 <u>Copay</u> / visit; <u>deductible</u> does not apply	60% Coinsurance	Unlimited Virtual Care Visits received from Ambetter Telehealth covered at No Charge, providers covered in full, deductible does not apply.
If you visit a health care provider's office or clinic	Specialist visit	\$90 Copay / visit; deductible does not apply	60% Coinsurance	Covered No Limit.
or clinic	Preventive care/screening/ immunization	No charge; <u>deductible</u> does not apply	60% <u>Coinsurance</u> ; <u>deductible</u> does not apply	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	Diagnostic test (x-ray, blood work)	\$50 Copay / test; deductible does not apply for laboratory & professional services  50% Coinsurance for x- ray & diagnostic imaging  50% Coinsurance for laboratory & professional services and x-ray & diagnostic imaging at other places of service	60% Coinsurance for laboratory & professional services  60% Coinsurance for x-ray & diagnostic imaging  60% Coinsurance for laboratory & professional services and x-ray & diagnostic imaging at other places of service	Prior authorization may be required. Covered No Limit. Other places of service may include Hospital, Emergency Room, or Outpatient Facility.  Failure to obtain prior authorization for any service that requires prior authorization will result in a denial of benefits. See your policy for more details.
	Imaging (CT/PET scans, MRIs)	50% Coinsurance	60% Coinsurance	Prior authorization may be required. Covered No Limit.
If you need drugs to treat your illness or condition	Generic drugs (Tier 1)	Preferred Generic Retail: \$5 Copay / prescription; deductible does not apply Generic Retail: \$30 Copay / prescription; deductible does not apply	Not covered	Prior authorization may be required.  Prescription drugs are provided up to 30 days retail and up to 90 days through mail order.  Mail orders are subject to 2.5x retail cost-sharing amount.

<sup>\*</sup>For more information about limitations and exceptions, see <u>plan</u> or policy document at <u>https://api.centene.com/eoc/2022/62505OK012.pdf</u>.

Common		What You Will Pay		Limitations, Exceptions, & Other
Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information
More information about prescription drug coverage is available at https://ambetterofokla	Preferred brand drugs (Tier 2)  Non-preferred brand drugs (Tier 3)	Retail: 50% Coinsurance  Retail: 50% Coinsurance	Not covered	Prior authorization may be required.  Prescription drugs are provided up to 30 days retail and up to 90 days through mail order.  Mail orders are subject to 2.5x retail cost-
homa.com/2022formul ary	Specialty drugs (Tier 4)	Retail: 50% Coinsurance	Not covered	sharing amount.  Prior authorization may be required.  Prescription drugs are provided up to 30 days retail and up to 30 days through mail order.
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	50% Coinsurance	60% Coinsurance	Prior authorization may be required. Covered No Limit.
surgery	Physician/surgeon fees	50% Coinsurance	60% Coinsurance	Prior authorization may be required. Covered No Limit.
	Emergency room care	50% Coinsurance	50% Coinsurance	Covered No Limit.
If you need immediate medical attention	Emergency medical transportation	50% Coinsurance	50% <u>Coinsurance</u>	Covered No Limit. Note: Prior authorization is not required for emergency transport, however, all non-emergent transport requires prior authorization.
	Urgent care	\$50 <u>Copay</u> / visit; <u>deductible</u> does not apply	60% Coinsurance; deductible does not apply	Covered No Limit.
If you have a hospital	Facility fee (e.g., hospital room)	50% Coinsurance	60% Coinsurance	Prior authorization may be required. Covered No Limit.
stay	Physician/surgeon fees	50% Coinsurance	60% Coinsurance	Prior authorization may be required. Covered No Limit.
If you need mental health, behavioral health, or substance	Outpatient services	\$40 <u>Copay</u> /Office Visit ( <u>deductible</u> does not apply); 50% <u>Coinsurance</u> for other outpatient services	60% Coinsurance	Prior authorization may be required. Covered No Limit. (PCP and other practitioner visits do not require prior authorization).
abuse services	Inpatient services	50% Coinsurance	60% Coinsurance	Prior authorization may be required. Covered No Limit.
If you are pregnant	Office visits	\$40 <u>Copay</u> / visit; <u>deductible</u> does not apply	60% Coinsurance	Prior authorization not required for deliveries within the standard timeframe per federal regulation, but may be required for other

<sup>\*</sup>For more information about limitations and exceptions, see <u>plan</u> or policy document at <u>https://api.centene.com/eoc/2022/62505OK012.pdf</u>.

Common		What You Will Pay		Limitations, Exceptions, & Other	
Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information	
				services. Cost-sharing does not apply for preventive services, such as routine pre-natal and post-natal screenings. Depending on the type of services, coinsurance, deductible or copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).	
	Childbirth/delivery professional services	50% Coinsurance	60% Coinsurance	Prior authorization may be required. Cost- sharing does not apply for preventive	
	Childbirth/delivery facility services	50% Coinsurance	60% Coinsurance	services. Depending on the type of services, copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).	
	Home health care	50% Coinsurance	60% Coinsurance	Prior authorization may be required. Limited to 30 visits per year.	
If you need help recovering or have other special health needs	Rehabilitation services	50% Coinsurance	60% Coinsurance	Prior authorization may be required. Per year, a combined 25 visit limit applies for occupational, speech and physical therapy. Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis.	
	Habilitation services	50% Coinsurance	60% Coinsurance	Prior authorization may be required. Per year, a combined 25 visit limit applies for occupational, speech and physical therapy. Note: Habilitation therapy limits do not apply when provided for a mental health/substance use disorder diagnosis.	
	Skilled nursing care	50% Coinsurance	60% Coinsurance	Prior authorization may be required. Limited to 30 days per year.	
	Durable medical equipment	50% Coinsurance	60% Coinsurance	Prior authorization may be required. Covered No Limit.	
	Hospice services	50% Coinsurance	60% Coinsurance	Prior authorization may be required. Covered No Limit.	

<sup>\*</sup>For more information about limitations and exceptions, see <u>plan</u> or policy document at <u>https://api.centene.com/eoc/2022/62505OK012.pdf</u>.

Common	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other
Medical Event		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information
	Children's eye exam	No charge; deductible does not apply	Covered up to \$38.50; deductible does not apply	Limited to 1 visit per year. Out-of-network provider eye exam covered up to \$38.50.
If your child needs dental or eye care	Children's glasses	No charge; deductible does not apply	Covered up to \$50; deductible does not apply	Limited to 1 item per year. Out-of-network provider frames or contacts covered up to \$50, see schedule for lens limit.
	Children's dental check-up	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.)

- Abortion (Except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care

- Infertility treatment (Note: Coverage is available for diagnosis and services required to correct underlying medical causes of infertility.)
- Long-Term Care (Long Term Acute Care is a covered benefit. Long Term Nursing Care/ Custodial Care is not a covered benefit.)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Weight loss programs

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

- Chiropractic care
- Hearing aids (Limited to 1 per ear every 4 years.)
- Private-duty nursing (Limited to 85 visits per year.)
- Routine foot care (Coverage is limited to diabetes care only.)

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: Ambetter of Oklahoma at 1-833-492-0679 (TTY 711); Oklahoma Insurance Department, 400 NE 50th St. Oklahoma City, OK 73105 Other coverage options may be available to you too, including buying individual insurance coverage through the <a href="Health Insurance">Health Insurance</a> <a href="Marketplace">Marketplace</a>. For more information about the <a href="Marketplace">Marketplace</a>, visit <a href="https://www.HealthCare.gov">www.HealthCare.gov</a> 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>, appeal, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or

assistance, contact: Oklahoma Insurance Department, 400 NE 50th St. Oklahoma City, OK 73105 Additionally, a consumer assistance program can help you file your appeal. Contact 800-522-0071

#### 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? 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 1-833-492-0679 (TTY 711).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-492-0679 (TTY 711).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-833-492-0679 (TTY 711).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-492-0679 (TTY 711).

To see examples of how this <u>plan</u> 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 <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>	\$8,300
■ Specialist copayment	\$90
■ Hospital (facility) coinsurance	50%
Other coinsurance	50%

#### 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:

<u>Cost Sharing</u>			
<u>Deductibles</u>	\$8,100		
Copayments	\$600		
Coinsurance	\$0		
What isn't covered			
Limits or exclusions	\$60		
The total Peg would pay is	\$8,760		

# 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>	\$8,300
■ Specialist copayment	\$90
■ Hospital (facility) coinsurance	50%
■ Other <u>coinsurance</u>	50%

#### 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>	\$3,900	
Copayments	\$800	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$4,720	

## Mia's Simple Fracture (in-network emergency room visit and follow up

ouroj	
■ The <u>plan's</u> overall <u>deductible</u>	\$8,300
■ Specialist copayment	\$90
■ Hospital (facility) coinsurance	50%
■ Other coinsurance	50%

#### 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:

Cost Sharing		
<u>Deductibles</u>	\$2,500	
Copayments	\$300	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$2,800	



Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter of Oklahoma, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-833-492-0679 (TTY 711).
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter of Oklahoma , 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 1-833-492-0679 (TTY 711).
Chinese:	如果您,或是您正在協助的對象,有關於 Ambetter of Oklahoma 方面的問題,您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話,請撥電話 1-833-492-0679 (TTY 711)。
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter of Oklahoma 에 관해서 질문이 있다면 그러한 도움과 정보를 귀하의 언어로
Norean.	비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-833-492-0679 (TTY 711)번으로 전화하십시오.
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter of Oklahoma hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-833-492-0679 (TTY 711) an.
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حولAmbetter of Oklahoma، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ  3-833-492-9790 (TTY 711).
Burmese:	သင် သို့မဟုတ် သင်ကူညီပေးနေသော တစ်ယောက်ယောက်တွင် Ambetter of Oklahoma နှင့် ပက်သက်ပြီး မေးမြန်းလိုသည်များ ရှိလျှင် အကူအညီ နှင့်
buillese.	အချက်အလက်များကို သင့်ဘာသာစကားဖြင့် အခမဲ့ ရယူပိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန်တစ်ယောက် နှင့် ပြောဆိုရန် 1-833-492-0679 (TTY 711) ကို ဖုန်းဆက်ပါ။
Hmong:	Yog koj, los yog ib tug neeg uas koj pab ntawd, muaj lus nug txog Ambetter of Oklahoma koj muaj cai tau txais tej ntub ntawv no sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 1-833-492-0679 (TTY 711)
Tagalog:	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter of Oklahoma, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-833-492-0679 (TTY 711).
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter of Oklahoma, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-833-492-0679 (TTY 711).
Laotion:	ຖ້າທ່ານ ຫຼືຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ ມີຄຳຖາມກ່ຽວກັບ Ambetter of Oklahoma, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານ ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຈະເວົ້າກັບນາຍພາສາ ໃຫ້ໂທຫາ 1-833-492-0679 (TTY 711).
Thai:	หากท่านหรือผู้ที่ท่านให้ความช่วยเหลืออยู่ในขณะนี้มีคำถามเกี่ยวกับAmbetter of Oklahoma ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่าน โดยไม่เสียค่าใช้จ่ายใด ๆ ทั้งสิ้น หากต้องการใช้บริการล่าม กรุณาโทรศัพท์ติดต่อที่หมายเลข 1-833-492-0679 (TTY 711).
Urdu:	اگر Ambetter of Oklahoma کے بار ہے میں آپ کے، یا جن کی آپ مدد کر رہے ہیں، ان کے سوالات ہوں تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی مترجم سے بات کرنے کے لیے 1-833-992-9679 (TTY 711) پر کال کریں۔
Cherokee:	AA Do AASPAY A4 DOT&AY EGSOT Ambetter of Oklahoma, VG D4 RASIT Do RGZA4I േക് CUAAAI AS EGTA. A&ZPI YG DЛIAY IAO 1-833-492-0679 (TTY 711)
Persian:	اگر شما، یا کسي که به او کمک مي کنید سؤالي در مورد Ambetter of Oklahoma دارید، از این حق برخوردارید که کمک و اطلاعات را بصورت رایگان به زیان خود دریافت کنید۔ براي صحبت کردن با مترجم با شماره 1-833-492-4990 (TTY 711) تماس بگیرید۔

#### Statement of Non-Discrimination

Ambetter of Oklahoma complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Ambetter of Oklahoma does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

#### Ambetter of Oklahoma:

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

If you need these services, contact Ambetter of Oklahoma at 1-833-492-0679 (TTY 711).

If you believe that Ambetter of Oklahoma has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Ambetter of Oklahoma, Appeals and Grievances, PO Box 10341 Van Nuys CA, 91410, 1-833-492-0679 (TTY 711), Fax 1-833-886-7956. You can file a grievance by mail, fax, or email. If you need help filing a grievance, Ambetter of Oklahoma is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <a href="https://ocrportal.hhs.gov/ocr/portal/lobby.jsf">https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</a>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <a href="http://www.hhs.gov/ocr/office/file/index.html">http://www.hhs.gov/ocr/office/file/index.html</a>.