



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, visit

<https://ambetterofoklahoma.com/2022-brochures.html>, or call 1-833-492-0679 (TTY 711). 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 1-833-492-0679 (TTY 711) to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|---|
| What is the overall deductible ? | Network providers : \$8,100 Individual / \$16,200 Family. Out-of-network providers : \$15,000 Individual / \$30,000 Family. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible . |
| Are there services covered before you meet your deductible ? | Yes. Preventive care services, urgent care office visits, children's eye exam and glasses, generic and preferred brand drugs are covered before you meet your deductible . | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | No. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan ? | For network providers : \$8,700 Individual / \$17,400 Family. For out-of-network providers : Not applicable Individual / Not applicable Family. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit 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 network provider ? | Yes. See https://ambetterofoklahoma.com/fi ndadoc or call 1-833-492-0679 (TTY 711) for a list of network providers . | This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do you need a referral to see a specialist ? | 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.

| 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 provider's office or clinic | Primary care visit to treat an injury or illness | \$45 Copay / visit; deductible 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. |
| | Specialist visit | \$100 Copay / visit; deductible does not apply | 60% Coinsurance | Covered No Limit. |
| | Preventive care/screening/immunization | No charge; deductible does not apply | 60% Coinsurance ; deductible does not apply | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan 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 | 60% Coinsurance for laboratory & professional services | 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. |
| | | 50% Coinsurance for x-ray & diagnostic imaging | 60% 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 and x-ray & diagnostic imaging at other places of service | |
| | 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 | 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. |

| 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) | |
| More information about prescription drug coverage is available at https://ambetterofoklahoma.com/2022formulary . | | Generic Retail: \$25 Copay / prescription; deductible does not apply | | |
| | Preferred brand drugs (Tier 2) | Retail: \$75 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. |
| | Non-preferred brand drugs (Tier 3) | Retail: 50% Coinsurance | Not covered | |
| | Specialty drugs (Tier 4) | Retail: 50% Coinsurance | Not covered | 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 surgery | Facility fee (e.g., ambulatory surgery center) | 50% Coinsurance | 60% Coinsurance | Prior authorization may be required. Covered No Limit. |
| | Physician/surgeon fees | 50% Coinsurance | 60% Coinsurance | Prior authorization may be required. Covered No Limit. |
| If you need immediate medical attention | Emergency room care | 50% Coinsurance | 50% Coinsurance | Covered No Limit. |
| | Emergency medical transportation | 50% Coinsurance | 50% Coinsurance | Covered No Limit. Note: Prior authorization is not required for emergency transport, however, all non-emergent transport requires prior authorization. |
| | Urgent care | \$60 Copay / visit; deductible does not apply | 60% Coinsurance ; deductible does not apply | Covered No Limit. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 50% Coinsurance | 60% Coinsurance | Prior authorization may be required. Covered No Limit. |
| | Physician/surgeon fees | 50% Coinsurance | 60% Coinsurance | Prior authorization may be required. Covered No Limit. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$45 Copay /Office Visit (deductible does not apply); 50% Coinsurance for other outpatient services | 60% Coinsurance | Prior authorization may be required. Covered No Limit. (PCP and other practitioner visits do not require prior authorization). |
| | Inpatient services | 50% Coinsurance | 60% Coinsurance | Prior authorization may be required. Covered No Limit. |

| 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 are pregnant | Office visits | \$45 Copay / visit; deductible does not apply | 60% Coinsurance | Prior authorization not required for deliveries within the standard timeframe per federal regulation, but may be required for other 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 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). |
| | Childbirth/delivery facility services | 50% Coinsurance | 60% Coinsurance | |
| If you need help recovering or have other special health needs | Home health care | 50% Coinsurance | 60% Coinsurance | Prior authorization may be required. Limited to 30 visits per year. |
| | 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. |

| 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) | |
| | 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. |
| If your child needs dental or eye care | 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. |
| | 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 .) | | |
|---|--|--|
| <ul style="list-style-type: none"> • Abortion (Except in cases of rape, incest, or when the life of the mother is endangered) • Acupuncture • Bariatric surgery • Cosmetic surgery • Dental care | <ul style="list-style-type: none"> • 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.) | <ul style="list-style-type: none"> • 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.) | | |
| <ul style="list-style-type: none"> • Chiropractic care • Hearing aids (Limited to 1 per ear every 4 years.) | <ul style="list-style-type: none"> • Private-duty nursing (Limited to 85 visits per year.) | <ul style="list-style-type: none"> • 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 [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 on how 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: 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, kwijigo holne' 1-833-492-0679 (TTY 711).

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 plan's overall deductible | \$8,100 |
| ■ Specialist copayment | \$100 |
| ■ 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 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <u>Cost Sharing</u> | |
|-----------------------------------|----------------|
| Deductibles | \$8,100 |
| Copayments | \$600 |
| Coinsurance | \$0 |
| <u>What isn't covered</u> | |
| 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 plan's overall deductible | \$8,100 |
| ■ Specialist copayment | \$100 |
| ■ Hospital (facility) coinsurance | 50% |
| ■ Other coinsurance | 50% |

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 | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| <u>Cost Sharing</u> | |
|-----------------------------------|----------------|
| Deductibles | \$800 |
| Copayments | \$1,800 |
| Coinsurance | \$0 |
| <u>What isn't covered</u> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$2,620 |

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

| | |
|---|---------|
| ■ The plan's overall deductible | \$8,100 |
| ■ Specialist copayment | \$100 |
| ■ Hospital (facility) coinsurance | 50% |
| ■ Other coinsurance | 50% |

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic tests](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

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

In this example, Mia would pay:

| <u>Cost Sharing</u> | |
|-----------------------------------|----------------|
| Deductibles | \$2,500 |
| Copayments | \$300 |
| Coinsurance | \$0 |
| <u>What isn't covered</u> | |
| 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 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 تساعد أسئلة حولAmbetter of Oklahoma، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 0679-492-833-1 (TTY 711). |
| Burmese: | သင် သို့မဟုတ် သင့်ကူညီပေးနေသော တစ်ယောက်ယောက်တွင် Ambetter of Oklahoma နှင့် ပက်သက်ပြီး မေးမြန်းလိုသည်များ ရှိလျှင် အကူအညီ နှင့် 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, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຈະເວົ້າກັບນາຍພາສາ ໃຫ້ໃບໂທຫາ 1-833-492-0679 (TTY 711). |
| Thai: | หากท่านหรือผู้ที่ท่านให้ความช่วยเหลืออยู่ในขณะนี้มีคำถามเกี่ยวกับAmbetter of Oklahoma ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่เสียค่าใช้จ่ายใด ๆ ทั้งสิ้น หากต้องการใช้บริการล่าม กรุณาโทรศัพท์ติดต่อที่หมายเลข1-833-492-0679 (TTY 711). |
| Urdu: | اگر Ambetter of Oklahoma کے بارے 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 0679-492-833-1 (TTY 711) پر کال کریں۔ |
| Cherokee: | ᏍᎩ ᏈᎦ ᏅᏁᏉᏯᏱ ᏚᏐ ᏈᎦᏴᏭᏰᏱ ᏪᏌᏆᏰᏱ Ambetter of Oklahoma, ᏕᏆ ᏈᎦ ᏲᏁᏉᏯᏱ ᏈᎦ ᏲᏌᏆᏰᏱ ᏇᏱᏵᏍᎩᏱ ᏍᎩ ᏪᏌᏆᏰᏱ. ᏅᏍᏋᏰᏱ ᏕᏌ ᏈᎦᏱᏱᏱ ᏪᏱᏱ 1-833-492-0679 (TTY 711) |
| Persian: | اگر شما، یا کسی که به او کمک می کنید سؤالی در مورد Ambetter of Oklahoma دارید، از این حق برخوردارید که کمک و اطلاعات را بصورت رایگان به زبان خود دریافت کنید. برای صحبت کردن با مترجم با شماره 0679-492-833-1 (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 <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, 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 <http://www.hhs.gov/ocr/office/file/index.html>.