



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, [www.harvardpilgrim.org/public/eoc?pdid=PD0000202458](http://www.harvardpilgrim.org/public/eoc?pdid=PD0000202458). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other [underlined](#) terms, see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary.com](http://www.healthcare.gov/sbc-glossary.com) or call 1-888-333-4742 to request a copy.

Important Questions	Answers	Why This Matters:
<a href="#">What is the overall deductible?</a>	\$1,000 member/ \$2,000 family  Benefits are administered on a Plan Year basis	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<a href="#">Are there services covered before you meet your deductible?</a>	Yes. Tier 1 and Tier 2 <a href="#">prescription drugs</a> , <a href="#">preventive care</a> , <a href="#">provider</a> office visits, ambulatory surgery from Flex <a href="#">Providers</a> , routine eye exams are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<a href="#">Are there other deductibles for specific services?</a>	Yes. <a href="#">Prescription Drug Deductible</a> : \$200/member  There are no other specific <a href="#">deductibles</a>	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these <a href="#">services</a> .
<a href="#">What is the out-of-pocket limit for this plan?</a>	\$7,000 member/ \$14,000 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<a href="#">What is not included in the out-of-pocket limit?</a>	Pediatric Dental Care, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<a href="#">Will you pay less if you use a network provider?</a>	Yes. See <a href="https://www.harvardpilgrim.org/public/find-a-provider">https://www.harvardpilgrim.org/public/find-a-provider</a> or call 1-888-333-4742 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a>

Important Questions	Answers	Why This Matters:
		might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes.	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .



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	Level 1: \$25 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	Not covered	None
	<a href="#">Specialist</a> visit	Level 1: \$25 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply Level 2: \$50 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	Not covered	None
	<a href="#">Preventive care</a> / <a href="#">screening</a> / <a href="#">immunization</a>	No charge; <a href="#">deductible</a> does not apply	Not covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	X-rays: \$50 <a href="#">copay</a> /visit Laboratory Flex <a href="#">Providers</a> : \$0 <a href="#">copay</a> / <a href="#">coinsurance</a> Other <a href="#">Plan Providers</a> : \$45 <a href="#">copay</a> /visit	Not covered	None
	Imaging (CT/PET scans, MRIs)	Non-Hospital Based: \$250 <a href="#">copay</a> /procedure Hospital Based: \$500 <a href="#">copay</a> /procedure	Not covered	None
If you need drugs to treat your illness or condition  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.harvardpilgrim.org/2026CoreMA5T">www.harvardpilgrim.org/2026CoreMA5T</a> .	Generic drugs	30-day Retail Tier 1: \$5 <a href="#">copay</a> /prescription; <a href="#">deductible</a> does not apply 90-day Mail Tier 1: \$10 <a href="#">copay</a> /prescription; <a href="#">deductible</a> does not apply 30-day Retail Tier 2: \$30 <a href="#">copay</a> /prescription;	Not covered	Core MA formulary - covers a limited list; not all drugs are covered. You pay retail price for Out of Network pharmacy drugs and are reimbursed minus applicable <a href="#">cost sharing</a> . Covered only outside of service area.

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)	
<b>If you need prescription drugs</b>		<u>deductible</u> does not apply 90-day Mail Tier 2: \$60 <u>copay</u> /prescription; <u>deductible</u> does not apply		Some drugs must be obtained through a Specialty Pharmacy.
	Preferred brand drugs	30-day Retail Tier 3: \$150 <u>copay</u> /prescription 90-day Mail Tier 3: \$300 <u>copay</u> /prescription	Not covered	
	Non-preferred brand drugs	30-day Retail Tier 4: \$225 <u>copay</u> /prescription 90-day Mail Tier 4: \$675 <u>copay</u> /prescription	Not covered	
	<u>Specialty drugs</u>	30-day Retail Tier 4: \$225 <u>copay</u> /prescription 90-day Mail Tier 4: \$675 <u>copay</u> /prescription 30-day Retail Tier 5: 20% <u>coinsurance</u> up to \$250 90-day Mail Tier 5: 20% <u>coinsurance</u> up to \$750	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Flex <u>Providers</u> : \$250 <u>copay</u> /visit; <u>deductible</u> does not apply Other <u>Plan Providers</u> : \$500 <u>copay</u> /visit	Not covered	None
	Physician/surgeon fees	Flex <u>Providers</u> : No charge; <u>deductible</u> does not apply Other <u>Plan Providers</u> : \$0 <u>copay</u> / <u>coinsurance</u>	Not covered	
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$500 <u>copay</u> /visit		None
	<u>Emergency medical transportation</u>	\$0 <u>copay</u> / <u>coinsurance</u>		None
	<u>Urgent care</u>	Urgent care center: \$50 <u>copay</u> /visit	Urgent care center: Not covered	Non-participating <u>provider's</u> only covered outside the service area. <u>Cost sharing</u> may vary based on location.

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)	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$750 <a href="#">copay</a> /admit	Not covered	None
	Physician/surgeon fees	\$0 <a href="#">copay</a> / <a href="#">coinsurance</a>	Not covered	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$25 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	Not covered	None
	Inpatient services	\$750 <a href="#">copay</a> /admit	Not covered	
<b>If you are pregnant</b>	Office visits	\$25 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	Not covered	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> (such as routine prenatal visits).
	Childbirth/delivery professional services	\$0 <a href="#">copay</a> / <a href="#">coinsurance</a>	Not covered	
	Childbirth/delivery facility services	\$750 <a href="#">copay</a> /admit	Not covered	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	\$0 <a href="#">copay</a> / <a href="#">coinsurance</a>	Not covered	None
	<a href="#">Rehabilitation services</a>	Physical Therapy: Non-Hospital based: \$50 <a href="#">copay</a> /visit Hospital based: \$75 <a href="#">copay</a> /visit Occupational Therapy: Non-Hospital: \$50 <a href="#">copay</a> /visit Hospital based: \$75 <a href="#">copay</a> /visit Speech Therapy: Non-Hospital Based: \$50 <a href="#">copay</a> /visit Hospital based: \$75 <a href="#">copay</a> /visit	Not covered	Physical & occupational therapy - 60 combined visits/Plan Year.
	<a href="#">Habilitation services</a>			
	<a href="#">Skilled nursing care</a>	\$750 <a href="#">copay</a> /admit	Not covered	100 days/Plan Year.
	<a href="#">Durable medical equipment</a>	35% <a href="#">coinsurance</a>	Not covered	1 synthetic monofilament wig/Plan Year.
	<a href="#">Hospice services</a>	\$0 <a href="#">copay</a> / <a href="#">coinsurance</a>	Not covered	For inpatient see "If you have a hospital stay"

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 your child needs dental or eye care	Children's eye exam	\$25 <u>copay</u> /visit; <u>deductible</u> does not apply	Not covered	1 exam/ Plan Year
	Children's glasses	Reimbursed first \$50, then 50% of covered charges; <u>deductible</u> does not apply		Frames & lenses every 12 months OR 1st order of contacts up to end of month child turns 19
	Children's dental check-up	No charge; <u>deductible</u> does not apply		2 exams/every 12 months up to end of month child turns 19

### 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.)

- Cosmetic Surgery
- Non-emergency care when traveling outside the U.S.
- Dental Care (Adult)
- Private-duty nursing
- Long-Term Care
- Routine foot care (except for diabetes or systemic circulatory diseases)
- Services that are not Medically Necessary

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

- Abortion
- Chiropractic care
- Acupuncture
- Hearing Aids - \$2,000/hearing aid every 36 months/impaired ear up to age 22
- Weight loss programs - 3 months of Weight Watchers traditional OR at Work/Plan Year
- Bariatric surgery
- Infertility treatment

**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: the Department of Labor, Employee Benefits Security Administration at **1-866-444-EBSA (3272)** or [www.dol.gov/ebsa/healthreform](http://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](http://www.cciio.cms.gov), or for more information on your rights to continue coverage, you can contact the Member Service number listed on your ID card or call **1-888-333-4742**. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](http://HealthInsuranceMarketplace.gov). For more information about the [Marketplace](http://Marketplace.gov), visit [www.HealthCare.gov](http://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:

HPHC Member Appeals-  
Member Services Department

Department of Labor's Employee  
Benefits Security Administration

Health Care for All  
30 Winter Street, Suite 1004

Massachusetts Division of Insurance  
1000 Washington Street, Suite 810

Harvard Pilgrim Health Care, Inc.  
1 Wellness Way Canton, MA 02021-  
1166

**Telephone:** 1-888-333-4742  
**Fax:** 1-617-509-3085

Benefits Security Administration  
**1-866-444-3272**  
[www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

Boston, MA 02108  
**1-800-272-4232**  
<http://www.hcfama.org/helpline>

Boston, MA 02118-6200  
**1-617-521-7794**

### **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 [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:**

Para obtener asistencia en Español, llame al **1-888-333-4742**.

如果需要中文的帮助, 请拨打这个号码 **1-888-333-4742**.

De assistência em Português, por favor ligue **1-888-333-4742**.

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](#)
- [Specialist copayment](#)
- Hospital (facility) [copayment](#)
- Other [copayment](#)

**This EXAMPLE event includes services like:**

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic Test](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

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

Cost Sharing	
Deductibles	\$1,000
Copayments	\$900
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$1,900

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#)
- [Specialist copayment](#)
- Hospital (facility) [copayment](#)
- Other [copayment](#)

**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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$300
Copayments	\$3,100
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$3,400

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#)
- [Specialist copayment](#)
- Hospital (facility) [copayment](#)
- Other [copayment](#)

**This EXAMPLE event includes services like:**

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

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$700
Coinsurance	\$90
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,790

# Language Assistance Services

**Arabic (العربية)** انتبه: إذا كنت تتحدث لغة أخرى غير الإنجليزية، فإن خدمات المساعدة اللغوية متاحة لك مجاناً. يرجى الاتصال بالرقم الموجود على بطاقة هوية العضو الخاصة بك.

**French (Français)** ATTENTION : Si vous parlez une langue autre que l'anglais, des services d'assistance linguistique gratuits sont à votre disposition. Veuillez appeler le numéro indiqué sur votre carte d'adhérent.

**Greek (Ελληνικά)** ΠΡΟΣΟΧΗ: Εάν μιλάτε κάποια άλλη γλώσσα πέρα από τα αγγλικά, γλωσσικές υπηρεσίες χωρίς χρέωση είναι στη διάθεσή σας. Καλέστε τον αριθμό στην κάρτα μέλους σας.

**Gujarati (ગુજરાતી)** ધ્યાન આપો: જો તમે અંગ્રેજી સંવિચાર બીજી ભાષા બોલો છો, તો ભાષા હિન્દી વિાઓ, તમારા માટે મહત ઉપલબ્ધ છે. કૃપા કરીને તમારા ભિન્ન આઈડી કાર્ડ પરના નંબર પર કોલ કરો.

**Haitian Creole (Kreyòl Ayisyen)** ATANSYON: Si w pale yon lang ki pa Anglè, gen sèvis èd pou lang ki disponib gratis pou ou. Tanpri rele nimewo ki sou kat ID manm ou a.

**Hindi (हिन्दी)** ध्यान दें: अगर आप अंग्रेजी के अलावा कोई दूसरी भाषा बोलते हैं, तो भाषा सहायता सेवाएं आपके ललए ननश्विलक उपलब्ध हैं। कृपया आपो सदस्य आईडी कार्ड पर ददए गए नंबर पर कॉल करें।

**Italian (Italiano)** ATTENZIONE: se parli una lingua diversa dall'inglese, sono disponibili gratuitamente servizi di assistenza linguistica. Chiama il numero indicato sulla tua tessera membro identificativa.

**Khmer (កម្ពុជា)** បូសនទាហ័រ កនិយាយភាសាបាសដោយបុរីពិភាក្សាអង់គ្លេស និងភាគមួយចុន្លឹម យកការ ដែលកតលិតខ្ចុលា ឱ្យអាជាក្រាវសហមន្ទ ការ សូម មុខិជ្ជការ ចាប់ផ្តើមជាបី ID ការពាណិជ្ជការនៃអ្នក ក្នុង

**Korean (한국어)** 알림: 영어 이외의 언어를 사용하신다면 언어 지원 서비스를 무료로 제공해 드립니다. 가입자 ID 카드에 명시된 번호로 전화하시기 바랍니다.

**Lao (ພາສາລາວ)** ກະຊວງ ຂົບຖານ: ຖ້າ ໂມວເວົ້າພາສັກເປົ້າໃຫ້ເປັນ ນັບພາສາ ຄົງໂຈນ, ໂມວສາມາດຂົບປົວມີຕົນພາສາໄດ້ ໂດຍບໍ່ມີລາຍ ຂ່າ. ກະຊວງໂທຕາມເປົ້າໃຫ້ໃນ ບົດປະຈຳ ຕົວລະມາຊີກອນຈະ ໂຫວ.

**Polish (polski)** UWAGA: Jeśli posługiujesz się językiem innym niż angielski, możesz bezpłatnie korzystać z usług pomocy językowej. Zadzwoń pod numer podany na Twojej karcie członkowskiej.

**Portuguese (Português)** ATENÇÃO: caso fale outro idioma que não o inglês, são-lhe disponibilizados gratuitamente serviços de assistência linguística. Ligue para o número no seu cartão de identificação de membro.

**Russian (Русский)** ВНИМАНИЕ! Если вы не говорите на английском языке, то можете бесплатно воспользоваться услугами языковой поддержки.

Позвоните по номеру, указанному на вашей идентификационной карте участника.

**Spanish (Español)** ATENCIÓN: Si usted habla un idioma que no sea inglés, están disponibles para usted, sin costo, servicios de asistencia en otros idiomas. Llame al número que figura en su tarjeta de identificación de miembro.

**Traditional Chinese (繁體中文)** 注意事項：如果您講非英語的其他語言，我們可以為您提供免費的語言協助服務。請撥打您會員 ID 卡上的電話號碼。

**Vietnamese (Tiếng Việt)** LƯU Ý: Nếu quý vị nói ngôn ngữ khác không phải tiếng Anh, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Vui lòng gọi đến số điện thoại trên thẻ ID hội viên của quý vị.

**ATTENTION:** If you speak a language other than English, language assistance services, free of charge, are available to you. Please call the number on your member ID card.

# General Notice About Nondiscrimination and Accessibility Requirements

Harvard Pilgrim Health Care and its affiliates as noted below ("HPHC") comply with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex (including pregnancy, sexual orientation and gender identity). HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability or sex (including pregnancy, sexual orientation and gender identity).

## HPHC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters.

If you need these services, contact our Civil Rights Compliance Officer (see below for contact information).

If you believe that HPHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex (including pregnancy, sexual orientation and gender identity) you can file a grievance with:

## Point32Health Civil Rights Legal Coordinator

1 Wellness Way  
Canton, MA 02021-1166

866-750-2074, TTY service: 711  
Fax: 617-668-2754  
Email: [OCRCordinator@point32health.org](mailto:OCRCordinator@point32health.org)

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Compliance Officer 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, D.C. 20201  
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at [www.hhs.gov/ocr/office/file/index.html](http://www.hhs.gov/ocr/office/file/index.html)