SCHEDULE OF BENEFITS:
BMC HealthNet Plan
SILVER B

BOSTON MEDICAL CENTER HEALTHNet PLAN
A Qualified Health Plan and Employer Choice Direct Plan¤

PROVIDER NETWORK: Silver Network¤¤

This Schedule of Benefits provides a summary of your benefits and *member cost-sharing*. It also tells you the name of your *provider network* (see above). Please be sure to read the BMC HealthNet Plan Evidence of Coverage (EOC) for a full description of your benefits, including exclusions, and other *plan* provisions. All *covered services* must be *medically necessary* and some require prior authorization. Always check with your *provider* to find out if necessary prior authorization has been obtained. If any terms in this summary differ from those in your EOC, the terms of your EOC apply. Italicized words in this Schedule of Benefits are defined in your EOC. For more information about your benefits, and to find *network providers*, go to www.bmchp.org or call Member Services at 1-855-833-8120. BMCHP-SLVRB2018ver.1

Deductible (per *benefit year*)	**Amount**
Per individual *member*	$3,000 (includes Medical and Rx)
	$50 (Pediatric Dental – Type II and Type III Services only)
Per family	$6,000 (includes Medical and Rx)
Out-of-Pocket maximum (per *benefit year*)	**Amount**
Per individual *member*	$7,200 (includes Medical, Pediatric Dental*, and Rx) *$350 (Pediatric Dental, if applicable, counts toward the Individual and Family OOPM)
Per family	$14,400 (includes Medical, Pediatric Dental, and Rx)

Covered Services Note about Prior Authorization: Some services require prior authorization. Please see your EOC for more information.		**Your Cost (*Cost-sharing*)**
***Inpatient* Hospital Care**	Acute hospital inpatient care for medical, surgical and maternity services. See also, "Newborn Coverage", below.	30% coinsurance per admission after *deductible*
	Extended care in a chronic disease hospital.	30% coinsurance per admission after *deductible*
	Extended care in a rehabilitation hospital. *Benefit limit:* limited to 60 days per *benefit year*.	30% coinsurance per admission after *deductible*
	Extended care in a skilled nursing facility. *Benefit limit:* limited to 100 days per *benefit year*.	30% coinsurance per admission after *deductible*
	Mental health and substance abuse:+ *Inpatient* admission to a general or mental hospital, or substance abuse facility.	30% coinsurance per admission after *deductible*
Abortion		$500 *copayment* per visit after *deductible*
Allergy Services	Testing and Treatment.	$50 *copayment* per visit
	Lab tests.	See Lab Tests, below
	Allergy injections.	$10 per injection
Ambulance	Covered ambulance.	Nothing after *deductible*

Covered Services Note about Prior Authorization: Some services require prior authorization. Please see your EOC for more information.		**Your Cost (*Cost-sharing*)**
Autism Spectrum Disorder Services+	• *Outpatient* office visits. • *Outpatient* rehabilitation (physical, occupational, speech therapy and social work visits) – as is *medically necessary.* • Lab tests and other diagnostic tests. • Habilitative services.	You pay the *cost-sharing* applicable to the service(s) rendered.
Cardiac Rehabilitation	*Outpatient* services.	Nothing after *deductible*
Chemotherapy and Radiation Therapy	*Outpatient* services.	Nothing after *deductible*
Chiropractor Care	• *Outpatient* medical services, including supportive medical treatment services and spinal manipulation	$50 copayment per visit
	• Outpatient lab test and x-rays	See Lab test, X-rays and Other Test
Dialysis Services	*Outpatient* services.	Nothing after *deductible*
Durable Medical Equipment, Prosthetics, Orthotics, Medical Supplies, Medical Formulas and Low Protein Foods++	• Durable medical equipment. • Prosthetics. • Orthotics. • Medical supplies. • Medical formulas. • Wigs (scalp hair prostheses): • *Coinsurance* does not apply. • Low protein foods. • Ostomy supply. • Oxygen and respiratory equipment.	30% *coinsurance after deductible*
Early Intervention Services	For an eligible *child* through age 2.	Nothing
Emergency Services	Visits to an emergency room (or for observation services in a hospital setting without use of the emergency room).	$500 *copayment* per visit after *deductible* If you are admitted as an *inpatient* immediately following the provision of *emergency* services: • Your *emergency* services *copayment* is waived; and • If admitted to a non-*network hospital*, you or someone acting for you must call the plan within 2 working days. If you receive *emergency* services from a non-*network provider*, the *plan* pays up to the *allowed amount.*
Habilitative Services and Devices	O*utpatient* physical and occupational therapy as well as medically necessary Habilitative devices. *Benefit limit:* limited to 60 combined visits per *benefit year*. (*Benefit limit* does not apply to these services when provided to *members* with autism spectrum disorder, or when receiving early intervention services.)	30% Coinsurance after deductible
Hearing Aids for Children	For an eligible *child* age 21 or younger • *Benefit limit:* Covered for one hearing aid up to two thousand dollars ($2,000) every 36 months per hearing impaired ear.	30% *coinsurance after deductible*
	• Hearing aid evaluations and exams	$50 *copayment* per visit
	• Hearing aid related services and supplies	30% *coinsurance after deductible*
Hearing Exams	PCP exams and evaluations.	$30 *copayment* per visit
	Specialist exams and evaluations.	$50 *copayment* per visit
Home Health Care	Home care program.	Nothing after *deductible*
Hospice Services	Hospice services for terminally ill.	Nothing after *deductible*
Infertility Services	*Inpatient*, *outpatient surgery*; lab and x-rays; *outpatient* office visits; and prescription drugs.	You pay the *cost-sharing* applicable to the service(s) rendered.

Covered Services Note about Prior Authorization: Some services require prior authorization. Please see your EOC for more information.		**Your Cost (*Cost-sharing*)**
Lab Tests, Radiology and Other Outpatient Diagnostic Procedures (Non-Routine Diagnostic Services)	Diagnostic laboratory tests (includes HLA testing).	30% coinsurance after *deductible*
	X-rays.	30% coinsurance after *deductible*
	Diagnostic high tech imaging: CT/CTA scan, MRI/MRA, PET scan and NCI/NPI (nuclear cardiac imaging).	30% coinsurance after *deductible*
Lipodystrophy Syndrome Treatment	Medical and/or drug treatment such as reconstructive surgery (for example, suction assisted lipectomy)	You pay the *cost-sharing* applicable to the service(s) rendered.
	Other restorative procedures including dermal injections or fillers	
Long Term Antibiotic Therapy for Lyme Disease	Primary care provider (PCP) office visit.	$30 *copayment* per visit
	Specialist office visit.	$50 *copayment* per visit
Maternity Services	*Outpatient* prenatal office visits.	Nothing
	Outpatient postpartum office visits.	Nothing
Medical Formulas	Nonprescription enteral formulas and prescription formulas.	See Durable Medical Equipment
Medical Supplies	Includes ostomy, tracheostomy and oxygen supplies; and supplies for insulin pumps.	See Durable Medical Equipment
Mental Health and Substance Abuse Treatment – Outpatient+	*Outpatient* office visits.	$30 *copayment* per visit
	Medication-Assisted Treatment (MAT) and Associated Services for Opioid Dependence Note: See prescription drug section for medication details	Nothing Non-Medication Assisted Treatment services provided during the same encounter as Medication-Assisted Treatment visits (including but not limited to counseling and drug screening) may be subject to cost-sharing.
Nutritional Counseling	*Outpatient* office visits by a registered dietician.	Nothing
Outpatient Office Visits for Medical Care (to evaluate and treat illness or injury)	Primary care provider (PCP) office visit.	$30 *copayment* per visit
	Specialist office visit.	$50 *copayment* per visit
Outpatient Surgery	Same day surgery in a hospital or ambulatory surgery setting. (Includes diagnostic colonoscopies and endoscopies.)	$500 *copayment* per visit after *deductible*
Pediatric Dental++++ **(Ages 18 and under)**	Type I Services: Preventive & Diagnostic • Comprehensive Evaluation (Once per dentist per location) • Periodic Oral Exams (Twice per dentist location every 12 months) • Limited Oral evaluation (Two per calendar year per patient) • Oral evaluation under 3 years of age • Full Mouth X-Ray (Once per dentist location every 36 months) • Panoramic X-Ray(Once per dentist location every 36 months) • Bitewing X-Rays (Two per dentist location every 12 months) • Single Tooth X-Ray (As needed) • Teeth Cleaning (Twice every 12 months) • Fluoride Treatments (Once every 3 months) • Space Maintainers (covered)	Nothing

Covered Services Note about Prior Authorization: Some services require prior authorization. Please see your EOC for more information.		**Your Cost (*Cost-sharing*)**
Pediatric Dental++++ **(Ages 18 and under)** **(Continued)**	Type II Services: Basic Covered Services • Amalgam Restoration (Once per tooth per surface every 12 months) • Composite Resin Restorations (Once per tooth per surface every 12 months) • Recement crown/onlays (covered) • Rebase or reline dentures (Once with 24 months) • Root canals on permanent teeth (Once per tooth) • Prefabricated Stainless Steel Crowns (Four per patient per day) • Periodontal Scaling and Root Planing (Once per quadrant every 24 months) • Simple Extractions (covered.) • Surgical Extractions (covered.) • Vital pulpotomy (Limited to deciduous teeth) • Apicoectomy (Once per permanent tooth per lifetime) • Palliative care • Anesthesia (Allowed with covered	25% Coinsurance after deductible
	Type III Services: Major Restorative Services • Crown, resin (Once per tooth within 60 months) • Porcelain/ceramic crowns (Once per within 60 months)	50% Coinsurance after deductible
	Type IV Services: Orthodontia (Once per lifetime) (Covered only when medically necessary; patient must have severe and handicapping malocclusion as defined by HLD index score of 28 and/or one or more auto qualifiers; requires prior authorization)	50% Coinsurance
Pediatric Vision **(Ages 18 and under)**	• Conventional* Lenses: One pair every calendar year • Conventional* Frames: Covered once every calendar year • Contact Lenses: Covered once every calendar year – instead of eyeglasses	30% coinsurance after deductible
Podiatry Services	Non-routine foot care.	$50 *copayment* per visit
	Outpatient lab tests and x-rays.	See Lab Tests, X-Rays and Other Tests
	Routine foot care for diabetics.	Nothing
Prescription Drugs¤¤¤ **From a *network* Retail Pharmacy: (up to a 30-day supply)**	Tier 1	$30 *copayment after deductible*
	Tier 2	35% coinsurance after *deductible*
	Tier 3	35% coinsurance after *deductible*
Prescription Drugs¤¤¤ **From Mail Service Pharmacy: (up to a 90-day supply)**	Tier 1	$60 *copayment after deductible*
	Tier 2	35% coinsurance after *deductible*
	Tier 3	35% coinsurance after *deductible*
Prescription Drugs¤¤¤ for Medication-Assisted Treatment (MAT) and Associated Services for Opioid Dependence	Generic FDA-approved Drugs	$0 *copayment*
	Brand-Name FDA-approved Drugs	$0 *copayment*
	Opioid Antagonists (ex. Narcan)	$0 *copayment*
Note: You pay nothing for: (1) oral and other forms of prescription drug contraceptives; and (2) oral anti-cancer drugs.		

Covered Services Note about Prior Authorization: Some services require prior authorization. Please see your EOC for more information.		**Your Cost (*Cost-sharing*)**

Preventive Health Services
 	
The *plan* covers certain preventive health services, with no *cost-sharing*, in accordance with the *plan's* medical policy guidelines and the Affordable Care Act (ACA). For more information about which preventive services are included, see the Preventive Health Services section of your EOC, and visit the *plan's* website at www.bmchp.org or the federal government's website at www.healthcare.gov.
	• Preventive health services for children:
	  • Routine physical exams.
	  • Routine immunizations.
	  • Routine preventive screening tests.
	  • Routine hearing exams and tests (includes newborn hearing screening)
	  • Routine or preventive vision exams (one exam per member every 12 months).
	• Preventive health services for adults:
	  • Routine physical exams.
	  • Routine immunizations.
	  • Routine preventive screening tests and procedures (including screening colonoscopies).
	  • Routine hearing exams and tests.
	  • Routine or preventive vision exams (one exam per member every 24 months).
	• Preventive health services for women, including pregnant women:
	  • Routine GYN exams, including screening Pap smears.
	  • Prenatal care.
	  • Routine screening mammograms.
	  • Voluntary sterilization procedures.
		Nothing

Prosthetic Devices	Includes wigs (scalp hair prostheses) for hair loss due to treatment for cancer or leukemia.	See Durable Medical Equipment
Rehabilitation Therapies	Short term outpatient physical and occupational therapy. *Benefit limit:* limited to 60 combined visits per *benefit year*. (*Benefit limit* does not apply to these services when provided to *members* with autism spectrum disorder; or when receiving early intervention services.)	30% Coinsurance after deductible
	Aural and pulmonary therapy.	$50 copayment per visits
Second Opinions	*Outpatient second and third opinions*	See Outpatient Office Visits for Medical Care
Speech-Language and Hearing Disorder Services (no limits other than medical necessity)	*Outpatient* office visits for medical care.	See Outpatient Office Visits for Medical Care
	Outpatient speech therapy.	30% Coinsurance after deductible
	Outpatient diagnostic tests.	See Lab Tests, X-Rays and Other Tests
TMJ Disorder Treatment	*Outpatient* x-rays, surgical services, physical therapy or medical care services.	You pay the *cost-sharing* applicable to the service(s) rendered.
Vision Services	Non-routine eye exams and treatment (to treat a medical condition of the eye). Routine Vision Exams – see "Preventive Health Services" above.	$50 *copayment* per visit

Member Extras+++	• Fitness Reimbursement
	  o Reimbursement of 25% of annual membership fees in a Qualifying Health Club – limited to one *member* per family per calendar year.
	• Weight Watchers®
	  o Reimbursement of 25% of fees for certain Weight Watchers® programs – limited to one *member* per family per calendar year.
	• Eyewear Discounts for Adults
	  o You must use a Vision Services Provider (VSP):
	  ▪ 20% off the retail price of complete sets of prescription glasses – frames and lenses
	  ▪ 15% off the professional fee for prescription contact lens fitting and evaluation	

Member Incentives	• BMCHP VBID Program - $25 Gift Card
	  o Members with diabetes will automatically be enrolled in BMCHP Diabetes VBID program (Members may opt out of the program)
	  o Members who receive an annual eye exam will receive a $25 gift card	

Covered Services Note about Prior Authorization: Some services require prior authorization. Please see your EOC for more information.	**Your Cost (*Cost-sharing*)**
Newborn Coverage	• Newborns are automatically covered for routine nursery charges and well newborn care. Newborns must be enrolled in the *plan* within 30 days of date of birth in order for the *plan* to cover any other *medically necessary* services rendered to the newborn.

Note: In the course of receiving certain *outpatient* services (which may or may not be subject to *cost-sharing*), you may also receive other *covered services* that require separate *cost-sharing*. (For example, during a preventive health services office visit (no *cost-sharing*), you may have a lab test that does require *cost-sharing*.)

¤ Qualified Health Plans are offered through the MA Health Connector. Employer Choice Direct plans are offered directly from BMC HealthNet Plan to MA businesses.

¤¤ The BMC HealthNet Plan Silver Network may contain different *providers* from those in the *plan's* other *provider networks*. When looking up *network providers* on our website, please be sure to look under the BMC HealthNet Plan Silver Network.

¤¤¤ The *plan* contracts with EnvisionRx Options to manage prescription drug benefits for *members*. To locate *network pharmacies*, go to our website www.bmchp.org or call EnvisionRx Options at 1-800-361-4542.

+ The *plan* contracts with *Beacon Health Strategies*, *LLC* (*Beacon*) to manage all mental health and substance abuse services for members. To locate a *Network provider* of mental health or substance abuse services, go to our website www.bmchp.org or call Beacon at 1-877-957-5600.

++ The *plan* contracts with Northwood, Inc. to manage most durable medical equipment, prosthetics, orthotics, medical supplies, medical formulas and low protein foods. Contact the *plan's* Member Services for more information.

+++ See your EOC for further information on how to access these Member Extras, or visit www.bmchp.org.

++++ The plan contracts with Delta Dental to manage all pediatric dental covered services for eligible members. For assistance call Delta Dental at 1-844-260-6097.

*Conventional lenses are defined under the Federal Vision Insurance Plan as single vision, lined bifocal, lined trifocal, lenticular glass or plastic lenses, all lens powers, fashion and gradient tinting, ultraviolet protective coating, oversized and glass-grey #3 prescription sunglass lenses. Polycarbonate lenses are covered for children, monocular patients and patients with prescriptions greater than or equal to +/- 6.00 diopters. All lenses include scratch resistant coating.

Notice for American Indian and Alaskan Native (AI/AN) Members:
According to Federal law, you may be able to enroll in a QHP plan that has limited or no cost sharing. Depending on your income, you may have no copays, deductibles, or coinsurance when you receive services from an Indian Health or Tribal provider, or when your Indian Health or Tribal provider refers you to another provider. The Massachusetts Health Connector will determine your eligibility for this benefit when you submit your QHP application. In addition to verifying your income, the Health Connector may also ask for documentation that proves your AI/AN status. If you qualify, the Health Connector will send us your information so that we can share it with our providers. If you have any questions, you may reach out to the MA Health Connector or to Member Services 855-833-8120

This health plan **meets Minimum Creditable Coverage standards** and will satisfy the individual mandate that you have health insurance.

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE: As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

Minimum Creditable Coverage Standards. This health plan meets applicable Minimum Creditable Coverage standards that are effective January 1, 2017as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you will satisfy the statutory requirement that you have health insurance meeting these standards.

THIS DISCLOSURE IS FOR MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE EFFECTIVE January 1, 2018. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR HEALTH PLAN MATERIAL EACH YEAR TO DETERMINE WHETHER YOUR PLAN MEETS THE LATEST STANDARDS.

If you have questions about this notice, you may contact the Division of Insurance: (617) 521-7794 or visiting its website at www.mass.gov/doi.

If you, or someone you are helping, have questions about BMC HealthNet Plan, you have the right to get help and information in your language at no cost. To talk to an interpreter, call **1-855-833-8120**.

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص BMC HealthNetPlan، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل ب- **1-855-833-8120** (ARA).

របយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **1-855-833-8120**។ (CAM)

如果您，或是您正在協助的對象，有關於 BMC HealthNetPlan**方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話** **1-855-833-8120**。(CH)

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de BMC HealthNet Plan, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez **1-855-833-8120**. (FR)

Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις γύρω απο το BMC HealthNet Plan, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση.Για να μιλήσετε σε έναν διερμηνέα, καλέστε **1-855-833-8120.** (GR)

જો તમે અથવા તમે કોઇને મદદ કરી રહ્યાં તેમ ાંથી કોઇને BMC HealthNet Plan વશિે પ્રશ્નો હોર્ તો તમને મદદ અને મ હ્હતી મેળિવોનો અવકિ ર છે. તે ખર્ચ વનિ તમ રી ભ ષ મ ાં પ્ર પ્ત કરી શક ર્ છે. દ ભ વષરો િત કરિમ ટે,આ **1-855-833-8120** પર કોલ કરો. (GUJ)

Si oumenm oswa yon moun w ap ede gen kesyon konsènan BMC HealthNet Plan, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan **1-855-833-8120.** (HC)

यदि आपके ,या आप द्वारा सहायता ककए जा रहे ककसी व्यक्तत के BMC HealthNet Plan के बारे में प्रश्न हैं ,तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। ककसी भ्रि ाषषए से बात करने के लिए , **1-855-833-8120** पर कॉल करें। (HIN)

Se tu o qualcuno che stai aiutando avete domande su BMC HealthNet Plan, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare **1-855-833-8120.** (IT)

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 BMC HealthNet Plan 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 **1-855-833-8120** 로 전화하십시오. (KO)

Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie BMC HealthNet Plan, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozma-wiać z tłumaczem, zadzwoń pod numer **1-855-833-8120**. (POL)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre o BMC HealthNet Plan, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para **1-855-833-8120.** (PORT)

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу BMC Health-Net Plan, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону **1-855-833-8120.** (RUS)

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de BMC HealthNet Plan, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al **1-855-833-8120.** (SP)

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về BMC HealthNet Plan, 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 **1-855-833-8120**. (VIET)

Notice About Nondiscrimination and Accessibility Requirements and Nondiscrimination Statement: Discrimination is Against the Law

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

Boston Medical Center HealthNet Plan:

- 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 Boston Medical Center HealthNet Plan.

If you believe that Boston Medical Center HealthNet Plan 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:

Civil Rights Coordinator
529 Main Street, Suite 500
Charlestown, MA 02129
Phone: 1-855-833-8120 (TTY 711)
Fax: 1-617-897-0805

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Boston Medical Center HealthNet Plan 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
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are also available at http://www.hhs.gov/ocr/office/file/index.html.