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, http://healthplan.memorialhermann.org/brokers/resource-center/ or call 855-645-8448. 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.memorialhermann.org, https://www.healthcare.gov/sbc-glossary/ or call 855-645-8448 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall <strong>deductible</strong>?</td>
<td>Participating Providers - $2,500 person / $5,000 family. Non-Participating Providers - None.</td>
<td>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.</td>
</tr>
<tr>
<td>Are there services covered before you meet your <strong>deductible</strong>?</td>
<td>Yes. Preventive care services are covered before you meet your deductible. Does not apply to penalties, Generic, Preferred brand or Non-Preferred brand prescription drugs.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other <strong>deductibles</strong> for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services</td>
</tr>
<tr>
<td>What is the <strong>out-of-pocket limit</strong> for this <strong>plan</strong>?</td>
<td>Participating Providers - $5,500 person / $11,000 family. Non-Participating Providers – None.</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the <strong>out-of-pocket limit</strong>?</td>
<td>Copayments for certain services, premiums, balance-billing charges, penalties for failure to obtain prior authorization for services and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out–of–pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a <strong>network provider</strong>?</td>
<td>Yes. See <a href="http://healthplan.memorialhermann.org/brokers/find-a/?searchfor=doctors">http://healthplan.memorialhermann.org/brokers/find-a/?searchfor=doctors</a> or call 855-645-8448 for a list of Participating Providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a <strong>referral</strong> to see a <strong>specialist</strong>?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Participating Provider (You will pay the least)</th>
<th>Non-Participating Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$30 copay/visit; deductible does not apply</td>
<td>Not Covered</td>
<td>None.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$60 copay/visit; deductible does not apply</td>
<td>Not Covered</td>
<td>None.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunizations</td>
<td>No Charge; deductible does not apply</td>
<td>Not Covered</td>
<td>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.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>Lab - $30 copay/visit X-Ray - $60 copay/visit; deductible does not apply for Lab &amp; X-ray</td>
<td>Not Covered</td>
<td>Prior authorization required for Genetic Testing; Non-compliance may result in a penalty. Prior authorization required on all Imaging; Deductible applies first for Imaging.</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20%/visit</td>
<td>Not Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>Retail Preferred: $2 copay/prescription; Retail Non-Preferred: $10 copay/prescription Mail Order: $5 copay/prescription. Deductible does not apply</td>
<td>Not Covered</td>
<td>Lower cost applies at Preferred Participating Pharmacies. One copay per 30-day supply - up to a 90-day supply.</td>
</tr>
<tr>
<td></td>
<td>Preferred Brand drugs</td>
<td>Retail Preferred: $40 copay/prescription; Retail Non-Preferred: $50 copay/prescription Mail Order: $100 copay/prescription Deductible does not apply</td>
<td>Not Covered</td>
<td>Annual Participating Provider Deductible does NOT apply to Generic, Preferred Brand, and Non-Preferred Brand prescription drugs. Participating Provider prescription drug copayments/coinsurance apply to the Annual Participating Provider Maximum Out-of-Pocket.</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Brand drugs</td>
<td>Retail Preferred: $75 copay/prescription; Retail Non-Preferred: $85 copay/prescription Mail Order: $187.50</td>
<td>Not Covered</td>
<td>Member responsible for paying applicable copay, allowable claim amount, or the contracted rate of the prescription if less than the established copay. Prior Authorization required for some Drugs.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Participating Provider (You will pay the least)</th>
<th>Non-Participating Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty drugs*</td>
<td></td>
<td>copay/prescription; Deductible does not apply</td>
<td>Not Covered</td>
<td>*30-day supply only; $300 maximum per Specialty Drug per prescription per member; 90-day Mail Order not covered. Annual Participating Provider Deductible does NOT apply to Specialty Drugs. Prior Authorization required for some Specialty drugs.</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20%</td>
<td>Not Covered</td>
<td>Deductible applies first; Prior authorization is required. Non-compliance may result in a penalty.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20%</td>
<td>Not Covered</td>
<td>Deductible applies first.</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$300 copay then 20%/visit; deductible does not apply</td>
<td>$300 copay then 20%/visit; deductible does not apply</td>
<td>Copayment waived if admitted.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20%/trip</td>
<td>20%/trip</td>
<td>Deductible applies first.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$50 copay/visit; deductible does not apply</td>
<td>Not Covered</td>
<td>None.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20%</td>
<td>Not Covered</td>
<td>Deductible applies first; Prior authorization is required. Non-compliance may result in a penalty.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20%</td>
<td>Not Covered</td>
<td>Deductible applies first.</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Professional Office Visit - $30 copay/visit; deductible does not apply. Outpatient services - 20%/visit</td>
<td>Not Covered</td>
<td>Deductible applies first Outpatient Services; Prior Authorization required for Outpatient Services; Non-compliance may result in a penalty.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20%</td>
<td>Not Covered</td>
<td>Deductible applies first; Prior authorization is required. Non-compliance may result in a penalty.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>20%</td>
<td>Not Covered</td>
<td>Deductible applies first; Prior authorization is required. Non-compliance may result in a penalty. Cost sharing does not apply for preventive services. Depending on the type of services, a</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20%</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
<td>------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Participating Provider (You will pay the least)</td>
<td>Non-Participating Provider (You will pay the most)</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Childbirth/delivery facility services</td>
<td>20%</td>
<td>Not Covered</td>
<td>copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).</td>
</tr>
<tr>
<td></td>
<td>Home health care</td>
<td>20%/visit</td>
<td>Not Covered</td>
<td>Deductible applies first; Limited to 60 visits/year. Prior Authorization required. Non-compliance may result in a penalty.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20%</td>
<td>Not Covered</td>
<td>Deductible applies first for Rehabilitation &amp; Habilitation Services. Physical Therapy/ Occupational Therapy and Chiropractic: Limited to 20 combined visits/year; and 1 visit per day. (Limitation does not apply to services related to autism spectrum disorder or the treatment of developmental delay).</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>20%</td>
<td>Not Covered</td>
<td>Prior Authorization required for Inpatient &amp; ABA in Cognitive Therapy. Non-compliance may result in a penalty.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20%</td>
<td>Not Covered</td>
<td>Deductible applies first; Limited to 100 days/year. Prior authorization is required. Non-compliance may result in a penalty.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20%</td>
<td>Not Covered</td>
<td>Deductible applies first; Limited to Plan Requirements; Prior Authorization Required. Non-compliance may result in a penalty.</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>20%</td>
<td>Not Covered</td>
<td>Deductible applies first; Prior authorization required. Non-compliance may result in a penalty.</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>Primary Care Physician - $30 copay/visit; All other Providers - $60 copay/visit; deductible does not apply</td>
<td>Not Covered</td>
<td>One exam/year for children under age 20.</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>None.</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>None.</td>
</tr>
</tbody>
</table>
**Excluded Services & Other Covered Services:**

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Dental care (Adult)</td>
</tr>
<tr>
<td>• Infertility treatment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acupuncture (20 visits per year)</td>
</tr>
<tr>
<td>• Bariatric surgery (Prior Authorization required)</td>
</tr>
</tbody>
</table>

**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: Memorial Hermann Health Plan Customer Service at 855-645-8448 or [http://healthplan.memorialhermann.org](http://healthplan.memorialhermann.org); Texas Department of Insurance at 1-800-252-3439 or [http://www.tdi.texas.gov](http://www.tdi.texas.gov); for group health coverage subject to ERISA, U.S. Department of Labor Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [http://www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Church plans are not covered by the Federal COBRA continuation coverage rules. 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](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 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: For group health coverage subject to ERISA, U.S. Department of Labor Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [http://www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform); or Memorial Hermann Health Plan Customer Service at 855-645-8448 or [http://healthplan.memorialhermann.org](http://healthplan.memorialhermann.org).

**Does this plan provide Minimum Essential Coverage?** Yes.

If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet Minimum Value Standards?** 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:**

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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe’s type 2 Diabetes</th>
<th>Mia’s Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9 months of in-network pre-natal care and a hospital delivery)</td>
<td>(a year of routine in-network care of a well-controlled condition)</td>
<td>(in-network emergency room visit and follow up care)</td>
</tr>
<tr>
<td>□ The plan’s overall deductible <strong>$2,500</strong></td>
<td>□ The plan’s overall deductible <strong>$2,500</strong></td>
<td>□ The plan’s overall deductible <strong>$2,500</strong></td>
</tr>
<tr>
<td>□ Specialist copayment <strong>$60</strong></td>
<td>□ Specialist copayment <strong>$60</strong></td>
<td>□ Specialist copayment <strong>$60</strong></td>
</tr>
<tr>
<td>□ Hospital (facility) coinsurance <strong>20%</strong></td>
<td>□ Hospital (facility) coinsurance <strong>20%</strong></td>
<td>□ Hospital (facility) coinsurance <strong>20%</strong></td>
</tr>
<tr>
<td>□ Other coinsurance <strong>20%</strong></td>
<td>□ Other coinsurance <strong>20%</strong></td>
<td>□ Other coinsurance <strong>20%</strong></td>
</tr>
</tbody>
</table>

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** **$12,800**

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td><strong>$2,500</strong></td>
</tr>
<tr>
<td>Copayments</td>
<td><strong>$600</strong></td>
</tr>
<tr>
<td>Coinsurance</td>
<td><strong>$2,300</strong></td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions **$60**

**The total Peg would pay is** **$5,460**

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** **$7,400**

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles*</td>
<td><strong>$1,400</strong></td>
</tr>
<tr>
<td>Copayments</td>
<td><strong>$1,400</strong></td>
</tr>
<tr>
<td>Coinsurance</td>
<td><strong>$300</strong></td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions **$60**

**The total Joe would pay is** **$3,160**

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** **$1,900**

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles*</td>
<td><strong>$900</strong></td>
</tr>
<tr>
<td>Copayments</td>
<td><strong>$200</strong></td>
</tr>
<tr>
<td>Coinsurance</td>
<td><strong>$300</strong></td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions **$0**

**The total Mia would pay is** **$1,400**

Note: These numbers assume the patient does not participate in the plan’s wellness program. If you participate in the plan’s wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact Customer Service at: 855-645-8448.

The plan would be responsible for the other costs of these EXAMPLE covered services.
<table>
<thead>
<tr>
<th>Language</th>
<th>Translation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spanish</td>
<td>ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-594-0671.</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-594-0671.</td>
</tr>
<tr>
<td>Arabic</td>
<td>ملاحظة: إذا كنت تتحدث لغة أخرى، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل برقم 1-888-495-8888-495-1760.</td>
</tr>
<tr>
<td>Japanese</td>
<td>注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-594-0671まで、お電話にてご連絡ください。</td>
</tr>
<tr>
<td>Cantonese Chinese</td>
<td>注意：如果您說廣東話，您可以免費獲得語言援助服務。請致電1-888-594-0671。</td>
</tr>
<tr>
<td>Mandarin Chinese</td>
<td>注意：如果您说普通话，您可以免费获得语言援助服务。请致电1-888-594-0671。</td>
</tr>
<tr>
<td>Laotian</td>
<td>โปรดทราบ: ถ้าคุณพูดภาษาลาว, ทุกข์ฝุ่นสามารถได้รับความช่วยเหลือ, ได้รับการสนับสนุน, แม้ไม่พูดภาษาไทย. โทร 1-888-594-0671.</td>
</tr>
<tr>
<td>French</td>
<td>ATTENTION : Si vous parlez français, des services d’aide linguistique vous sont proposés gratuitement. Appelez le 1-888-594-0671.</td>
</tr>
<tr>
<td>Russian</td>
<td>ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-594-0671.</td>
</tr>
<tr>
<td>Gujarati</td>
<td>સુખના: જો તમે ગુજરાતી બોલતા હોવાથી, તો આપને કેટલાક ભાષા સહાય સેવાઓ મળશે. ટકાંની હોય 1-888-594-0671.</td>
</tr>
<tr>
<td>Tagalog</td>
<td>PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-594-0671.</td>
</tr>
<tr>
<td>Hindi</td>
<td>ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-594-0671 पर कॉल करें।</td>
</tr>
<tr>
<td>Urdu</td>
<td>خبردار: اگر آپ اردو بولتے بھیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں 1-888-594-0671.</td>
</tr>
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Memorial Hermann Health Plan, Inc., Memorial Hermann Health Insurance Company and Memorial Hermann Health Solutions, Inc. (collectively “MHHP”) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Memorial Hermann Advantage does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

MHHP:
- 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 Customer Service at the number below.

If you believe that MHHP 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
Memorial Hermann Health Plan
929 Gessner Road, Suite 1500
Houston, TX 77024

By calling the number on the back of your member ID card
Fax 713-338-6487
Email MHHealthAppeals@memorialhermann.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator 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, (1-800-537-7697 TDD).