# CareSource Federal Simple Choice Bronze

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

> ⚠️ **This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at CareSource.com/marketplace or by calling 1-888-815-6446.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall <u>deductible</u>?** | $6,650 individual/$13,300 family per benefit year. Deductible does not apply to copayments, physician home and office services for primary care, physician home and office services for specialty care, prescription drugs, preventive health services, urgent care services, and vision services – pediatric. | You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st.) See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. |
| **Are there other <u>deductibles</u> for specific services?** | No. | You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an <u>out–of–pocket</u> limit on my expenses?** | Yes. $7,150 individual/$14,300 family | The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the <u>out–of–pocket limit</u>?** | Premiums, balance-billed 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. |
| **Is there an overall annual limit on what the plan pays?** | No. | The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits. |
| **Does this plan use a <u>network</u> of <u>providers</u>?** | Yes. For a list of network providers, see CareSource.com/marketplace or call 1-888-815-6446. | If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs for covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers. |
| **Do I need a referral to see a <u>specialist</u>?** | No. | You can see the specialist you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about excluded services. |

**Questions:** Call 1-888-815-6446 or visit us at CareSource.com/marketplace.
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ADV-SBC-KY003(2017)-Bronze

KY-EXCM-0379

# CareSource Federal Simple Choice Bronze

**Coverage Period: 01/01/2017 – 12/31/2017**

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs    **Coverage for: Individual + Family | Plan Type: HMO**

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **in-network** **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $45/visit | Not covered. | First 3 visits, then deductible and 50% coinsurance. |
| | Specialist visit | 50% coinsurance after deductible | Not covered. | Plan covers 100% of allowed amount in excess of the copayment. Copayment waived when the only charge is for allergy injections/serum. If you receive services in addition to office visits, additional copayments, deductibles, or coinsurance may apply. |
| | Other practitioner office visit | 50% coinsurance after deductible | Not covered. | Manipulation therapy - 20 visits per benefit period. |
| | Preventive care/screening/immunization | $0/visit | Not covered. | 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) | X-ray: 50% coinsurance after deductible Lab: 50% coinsurance after deductible | Not covered. | --none-- |

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ADV-SBC-KY003(2017)-Bronze

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| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Imaging (CT/PET scans, MRIs) | 50% coinsurance after deductible | Not covered. | Prior authorization required. |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at CareSource.com/ marketplace | Generic drugs | Retail: $35 copay<br>Mail-Order: $35 copay | Not covered. | Retail: Up to a 31-day supply.<br>Mail-Order: Up to a 90-day supply.<br><br>There is no deductible for prescription drug coverage. You only pay the copayment/coinsurance. |
| | Preferred brand drugs | Retail: 35% coinsurance after deductible<br>Mail-Order: 35% coinsurance after deductible | Not covered. | Retail: Up to a 31-day supply.<br>Mail-Order: Up to a 90-day supply. |
| | Non-preferred brand drugs | Retail: 40% coinsurance after deductible<br>Mail-Order: 40% coinsurance after deductible | Not covered. | Retail: Up to a 31-day supply.<br>Mail-Order: Up to a 90-day supply.<br><br>Certain drugs may require a prior authorization.<br><br>You may be required to use a lower cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. |
| | Specialty drugs | Retail: 45% coinsurance after deductible<br>Mail-Order: 45% coinsurance after deductible | Not covered. | Retail: Up to a 31 day supply.<br>Mail-Order: Up to a 90 day supply. |
| | Specialty drugs non-preferred | Retail: Not Applicable<br>Mail-Order: Not Applicable | Not covered. | |

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| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 50% coinsurance after deductible | Not covered. | Prior authorization required. |
| | Physician/surgeon fees | 50% coinsurance after deductible | Not covered. | --none-- |
| **If you need immediate medical attention** | Emergency room services | 50% coinsurance after deductible | 50% coinsurance after deductible | Copayment waived if you are admitted to the hospital directly from the Emergency Department. |
| | Emergency medical transportation | 50% coinsurance after deductible | 50% coinsurance after deductible | --none-- |
| | Urgent care | 50% coinsurance after deductible | Not covered. | If you receive services in addition to urgent care, additional copayments, deductibles, or coinsurance may apply. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 50% coinsurance after deductible | Not covered. | Prior authorization required. |
| | Physician/surgeon fee | 50% coinsurance after deductible | Not covered. | --none-- |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/behavioral health outpatient services | $45/visit for office visits and 50% coinsurance after deductible for other outpatient services | Not covered. | Prior authorization required for all inpatient stays, partial hospitalization programs, and intensive outpatient services. |
| | Mental/behavioral health inpatient services | 50% coinsurance after deductible | Not covered. | |
| | Substance use disorder outpatient services | $45/visit for office visits and 50% coinsurance after deductible for other outpatient services | Not covered. | |
| | Substance use disorder inpatient services | 50% coinsurance after deductible | Not covered. | |

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| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you are pregnant** | Prenatal and postnatal care | 50% coinsurance after deductible | Not covered. | Copayment covers initial physician visit and all subsequent prenatal visits, postnatal visits, and physician delivery charges covered under the Global Maternity Fee. Additional copayments, deductibles, or coinsurance may apply depending on services rendered in addition to the Global Maternity Fee. |
| | Delivery and all inpatient services | 50% coinsurance after deductible | Not covered. | Your cost for inpatient services only. See above for physician delivery charges. |
| **If you need help recovering or have other special health needs** | Home health care | 50% coinsurance after deductible | Not covered. | 100 combined visits per benefit year. |
| | Autism   Occupational therapy   Speech therapy   Behavioral therapy | 50% coinsurance after deductible  50% coinsurance after deductible  $45/visit | Not covered. | 25 visits per benefit period. 25 visits per benefit period. |

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| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Rehabilitation services | | | |
| | Physical therapy | 50% coinsurance after deductible | | 25 visits per benefit period. |
| | Occupational therapy | 50% coinsurance after deductible | | 25 visits per benefit period. |
| | Speech therapy | 50% coinsurance after deductible | | 25 visits per benefit period. |
| | Pulmonary rehabilitation | 50% coinsurance after deductible | Not covered. | 25 visits per benefit period. |
| | Cardiac rehabilitation | 50% coinsurance after deductible | | 36 visits per benefit period. |
| | Chiropractic services | 50% coinsurance after deductible | | Manipulation therapy - 20 visits per benefit period. |
| | Post-cochlear implant aural therapy | 50% coinsurance after deductible | | 30 visits per benefit period. |
| | Cognitive rehabilitation therapy | 50% coinsurance after deductible | | 20 visits per benefit period. |
| | Habilitation services | 50% coinsurance after deductible | | |
| | Physical therapy | 50% coinsurance after deductible | | 25 visits per benefit period. |
| | Occupational therapy | 50% coinsurance after deductible | Not covered. | 25 visits per benefit period. |
| | Speech therapy | 50% coinsurance after deductible | | 25 visits per benefit period. |
| | Skilled nursing care | 50% coinsurance after deductible | Not covered. | Any combination of benefits for skilled nursing facility/inpatient rehabilitation services is limited to 90 days per calendar year. |
| | Durable medical equipment | 50% coinsurance after deductible | Not covered. | May require prior authorization. |

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| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Hospice service | No charge. | No charge. | Our payment will be no less than Medicare. Out of network is the same cost share as in-network benefit. |
| **If your child needs dental or eye care** | Children's eye exam | $0/visit | Not covered. | Limit of one routine eye exam per benefit year. |
| | Low vision exam | 50% coinsurance after deductible | Not covered. | 1 exam and follow-up visit every 5 years. |
| | Children's eye wear | 50% coinsurance after deductible | Not covered. | Limited to 1 pair per benefit year and 1 replacement pair if medically necessary. |
| | Children's dental | Not Applicable Not Applicable Not Applicable | Not covered. | |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

**Other Covered Services** (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Hearing aids
- Private duty nursing

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## Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to continue health coverage after it would otherwise end. For more information, contact us at 1-888-815-6446 or contact 1-800-595-6053. Other options to continue coverage are 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:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, contact the Kentucky Department of Insurance: 1-800-595-6053.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-815-6446.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-815-6446.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-888-815-6446.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-815-6446.

*———————To see examples of how this plan might cover costs for a sample medical situation, see the next page.———————*

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## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $420
- **Patient pays:** $7,120

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $6,650 |
| Copays | $20 |
| Coinsurance | $300 |
| Limits or exclusions | $150 |
| **Total** | **$7,120** |

### Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $50
- **Patient pays:** $5,350

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $5,270 |
| Copays | $0 |
| Coinsurance | $0 |
| Limits or exclusions | $80 |
| **Total** | **$5,350** |

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

✖ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

✖ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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ADV-SBC-KY003(2017)-Bronze

KY-EXCM-0379

If you, or someone you're helping, have questions about CareSource, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-888-815-6446 TTY:711.

## ARABIC

إذا كان لديك، أو لدى أي شخص تساعده، أية استفسارات بخصوص CareSource، فيحق لك الحصول على مساعدة ومعلومات مجانًا وباللغة التي تتحدث بها. للتحدث إلى أحد المترجمين الفوريين، اتصل على 1-888-815-6446 TTY:711.

## AMHARIC

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## BURMESE

CareSource အကြောင်း သင် သို့မဟုတ် သင်အကူအညီပေးနေသူ တစ်စုံတစ်ယောက်က မေးမြန်းလာပါက သင်ပြောဆိုသော ဘာသာစကားဖြင့် အကူအညီနှင့် အချက်အလက်များအား အခမဲ့ ရယူနိုင်ရန် အခွင့်အရေးရှိပါသည်။ ဘာသာပြန်တစ်ဦးအား စကားပြောဆိုရန် 1-888-815-6446 TTY:711 ၍တွင် နံပါတ်ဖြည့်သွင်းပါ] သို့ ခေါ် ဆိုပါ။

## CHINESE

如果您或者您在帮助的人对 CareSource 存有疑问，您有权免费获得以您的语言提供的帮助和信息。 如果您需要与一位翻译交谈，请致电 1-888-815-6446 TTY:711。

## CUSHITE – OROMO

Isin yookan namni biraa isin deeggartan CareSource irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1-888-815-6446 TTY:711 tiin bilbilaa.

## DUTCH

Als u, of iemand die u helpt, vragen heeft over CareSource, hebt u het recht om kosteloos hulp en informatie te ontvangen in uw taal. Als u wilt spreken met een tolk, bel dan naar 1-888-815-6446 TTY:711.

## FRENCH (CANADA)

Des questions au sujet de CareSource? Vous ou la personne que vous aidez avez le droit d'obtenir gratuitement du soutien et de l'information dans votre langue. Pour parler à un interprète, veuillez téléphoner au 1-888-815-6446 TTY:711.

## GERMAN

Wenn Sie, oder jemand dem Sie helfen, eine Frage zu CareSource haben, haben Sie das Recht, kostenfrei in Ihrer eigenen Sprache Hilfe und Information zu bekommen. Um mit einem Dolmetscher zu sprechen, rufen Sie die Nummer 1-888-815-6446 TTY:711 an.

## GUJARATI

જો તમે અથવા તમે કોઈને મદદ કરી રહ્યા તેમ થી કોઈને CareSource વિશે પ્રશ્નો હોર તો તમને મદદ અને માહિતી મેળવિનો અધિક ર છે. તે ખર્ચ વિના તમ રી ભ ષ મ પ પ્રપ્ત કરી શકર છે, દ ભ ષયર [ ત કરિ મ ટ,આ 1-888-815-6446 TTY:711 પર કોલે કરો.

## HINDI

यदि आपके, या आप जिसकी मदद कर रहे हैं उसके CareSource के बारे में कोई सवाल है तो आपके पास बगैर किसी लागत के अपनी भाषा में सहायता और जानकारी प्राप्त करने का अधिकार है। एक दुभाषिए से बात करने के लिए कॉल करें, 1-888-815-6446 TTY:711.

## ITALIAN

Se Lei, o qualcuno che Lei sta aiutando, ha domande su CareSource, ha il diritto di avere supporto e informazioni nella propria lingua senza alcun costo. Per parlare con un interprete, chiami il 1-888-815-6446 TTY:711.

## JAPANESE

ご本人様、または身の回りの方で、CareSource に関するご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます（無償）。 通訳をご利用の場合は、1-888-815-6446 TTY:711 にご連絡ください。

## KOREAN

귀하 본인이나 귀하께서 돕고 계신 분이 CareSource에 대해 궁금한 점이 있으시면, 원하는 언어로 별도 비용 없이 도움을 받으실 수 있습니다. 통역사가 필요하시면 다음 번호로 전화해 주십시오: 1-888-815-6446 TTY:711.

## PENNSYLVANIA DUTCH

Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut CareSource, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 1-888-815-6446 TTY:711 uffrufe.

## RUSSIAN

Если у Вас или у кого-то, кому Вы помогаете, есть вопросы относительно CareSource, Вы имеете право бесплатно получить помощь и информацию на Вашем языке. Для разговора с переводчиком, позвоните по номеру 1-888-815-6446 TTY:711.

## SPANISH

Si usted o alguien a quien ayuda tienen preguntas sobre CareSource, tiene derecho a recibir esta información y ayuda en su propio idioma sin costo. Para hablar con un intérprete, llame al 1-888-815-6446 TTY:711.

## UKRAINIAN

Якщо у вас, чи в особи, котрій ви допомагаєте, виникнуть запитання щодо CareSource, ви маєте право безкоштовно отримати допомогу та інформацію вашою мовою. Щоб замовити перекладача, зателефонуйте за номером 1-888-815-6446 TTY:711.

## VIETNAMESE

Nếu bạn hoặc ai đó bạn đang giúp đỡ, có thắc mắc về CareSource, bạn có quyền được nhận trợ giúp và thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, vui lòng gọi số 1-888-815-6446 TTY:711.

CareSource complies with applicable state and federal civil rights laws and does not discriminate on the basis of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status. CareSource does not exclude people or treat them differently because of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status.

CareSource provides free aids and services to people with disabilities to communicate effectively with us, such as: (1) qualified sign language interpreters, and (2) written information in other formats (large print, audio, accessible electronic formats, other formats).   In addition, CareSource provides free language services to people whose primary language is not English, such as: (1) qualified interpreters, and (2) information written in other languages.  If you need these services, please contact CareSource at 1-888-815-6446 TTY:711.

If you believe that CareSource has failed to provide the above mentioned services to you or discriminated in another way on the basis of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status, you may file a grievance, with:

CareSource
Attn: Civil Rights Coordinator
P.O. Box 1947, Dayton, Ohio 45401
1-844-539-1732, TTY: 711
Fax: 1-844-417-6254

CivilRightsCoordinator@CareSource.com

You can file a grievance by mail, fax, or email.  If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office of 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 available at http://www.hhs.gov/ocr/office/file/index.html.