



Medical Benefit Highlights

Keystone HMO Silver Proactive

Covered Services	Your Costs (You pay)			Out-of-Network
	Tier 1 - Preferred	Tier 2 - Enhanced	Tier 3 - Standard	
Benefits per Calendar Year				
Deductible (Embedded) ¹ Individual/Family	\$0/\$0	\$6,000/\$12,000		Not covered
Out-of-Pocket Maximum (Embedded) ² Individual/Family		\$8,700/\$17,400		Not covered
Coinsurance	0%	5%	10%	Not covered
Preventive Services	Tier 1 - Preferred	Tier 2 - Enhanced	Tier 3 - Standard	Out-of-Network
Preventive Care	No charge	No charge no deductible	No charge no deductible	Not covered
Preventive Colonoscopy				
Preventive Plus Providers	No charge	No charge no deductible	No charge no deductible	Not covered
Hospital Based	\$750	\$750 no deductible	\$750 no deductible	Not covered
Physician Services	Tier 1 - Preferred	Tier 2 - Enhanced	Tier 3 - Standard	Out-of-Network
Primary Care Physician (PCP)				
Office Visit	\$40	\$60 no deductible	\$70 no deductible	Not covered
Telemedicine Visit	\$30	\$40 no deductible	\$50 no deductible	Not covered
Specialist				
Office Visit	\$80	\$120 no deductible	\$140 no deductible	Not covered
Telemedicine Visit	\$55	\$80 no deductible	\$95 no deductible	Not covered
Retail Health Clinic Visit	\$40	\$60 no deductible	\$70 no deductible	Not covered
Urgent Care Visit	\$80	\$80 no deductible	\$80 no deductible	Not covered

Virtual Care³	Tier 1 - Preferred	Tier 2 - Enhanced	Tier 3 - Standard	Out-of-Network
Telemedicine	No charge	No charge no deductible	No charge no deductible	Not covered
Teledermatology	No charge	No charge no deductible	No charge no deductible	Not covered
Telebehavioral Health	No charge	No charge no deductible	No charge no deductible	Not covered
Therapy Services	Tier 1 - Preferred	Tier 2 - Enhanced	Tier 3 - Standard	Out-of-Network
Physical Therapy (30 visits/year)⁴				
Freestanding	\$80	\$80 no deductible	\$80 no deductible	Not covered
Hospital Based	\$80	\$80 no deductible	\$80 no deductible	Not covered
Occupational Therapy (30 visits/year)⁴				
Freestanding	\$80	\$80 no deductible	\$80 no deductible	Not covered
Hospital Based	\$80	\$80 no deductible	\$80 no deductible	Not covered
Speech Therapy (30 visits/year)	\$80	\$80 no deductible	\$80 no deductible	Not covered
Emergency Services	Tier 1 - Preferred	Tier 2 - Enhanced	Tier 3 - Standard	Out-of-Network
Emergency Room (copay not waived if admitted)	\$600	\$600 no deductible	\$600 no deductible	Covered at In-Network level
Emergency Ambulance	\$200	\$200 no deductible	\$200 no deductible	Covered at In-Network level
Non-Emergency Ambulance	\$250	\$250 no deductible	\$250 no deductible	Not covered
Hospital Services	Tier 1 - Preferred	Tier 2 - Enhanced	Tier 3 - Standard	Out-of-Network
Inpatient Hospital Services	\$600/Day; max of 5 copays per admission	Subject to deductible and \$900/Day; max of 5 copays per admission	Subject to deductible and \$1,300/Day; max of 5 copays per admission	Not covered
Maternity Hospital Services	\$600/Day; max of 5 copays per admission	Subject to deductible and \$900/Day; max of 5 copays per admission	Subject to deductible and \$1,300/Day; max of 5 copays per admission	Not covered
Inpatient Professional Services (includes Maternity)	No charge	5% after deductible	10% after deductible	Not covered

Outpatient Surgery	Tier 1 - Preferred	Tier 2 - Enhanced	Tier 3 - Standard	Out-of-Network
Freestanding	\$250	Subject to deductible and \$750	Subject to deductible and \$1,250	Not covered
Hospital Based	\$250	Subject to deductible and \$750	Subject to deductible and \$1,250	Not covered
Outpatient Professional Services	No charge	5% after deductible	10% after deductible	Not covered
Outpatient Diagnostics	Tier 1 - Preferred	Tier 2 - Enhanced	Tier 3 - Standard	Out-of-Network
Diagnostic Medical (EKG)	\$150	\$150 no deductible	\$150 no deductible	Not covered
Routine Radiology (X-Ray)				
Freestanding	\$150	\$150 no deductible	\$150 no deductible	Not covered
Hospital Based	\$150	\$150 no deductible	\$150 no deductible	Not covered
Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)				
Freestanding	\$300	\$300 no deductible	\$300 no deductible	Not covered
Hospital Based	\$300	\$300 no deductible	\$300 no deductible	Not covered
Outpatient Lab and Pathology	Tier 1 - Preferred	Tier 2 - Enhanced	Tier 3 - Standard	Out-of-Network
Freestanding	No charge	No charge no deductible	No charge no deductible	Not covered
Hospital Based	No charge	No charge no deductible	No charge no deductible	Not covered
Other Medical Services	Tier 1 - Preferred	Tier 2 - Enhanced	Tier 3 - Standard	Out-of-Network
Spinal Manipulations (20 visits/year)	\$50	\$50 no deductible	\$50 no deductible	Not covered
Acupuncture	Not covered	Not covered	Not covered	Not covered
Standard Injectables	30%	30% no deductible	30% no deductible	Not covered
Allergy Injections	30%	30% no deductible	30% no deductible	Not covered
Biotech/Specialty Injectables				
Home/Office	50%	50% no deductible	50% no deductible	Not covered
Outpatient	50%	50% no deductible	50% no deductible	Not covered
Chemotherapy	No charge	5% after deductible	10% after deductible	Not covered
Dialysis	\$30	\$90 no deductible	\$150 no deductible	Not covered



Skilled Nursing Facility (120 days/year)	\$300/Day; max of 5 copays per admission	\$300/Day; max of 5 copays per admission no deductible	\$300/Day; max of 5 copays per admission no deductible	Not covered
Home Health (60 visits/year)	No charge	5% after deductible	10% after deductible	Not covered
Hospice	No charge	No charge no deductible	No charge no deductible	Not covered
Durable Medical Equipment (DME)	50%	50% no deductible	50% no deductible	Not covered
Mental Health – Outpatient (includes serious mental illness and substance abuse)	\$80	\$80 no deductible	\$80 no deductible	Not covered
Mental Health – Inpatient (includes serious mental illness and substance abuse)	\$600/Day; max of 5 copays per admission	\$600/Day; max of 5 copays per admission no deductible	\$600/Day; max of 5 copays per admission no deductible	Not covered

- 1 Embedded deductible: Each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving plan benefits.
- 2 Embedded out-of-pocket maximum: Each covered family member only needs to satisfy his or her individual out-of-pocket maximum, not the entire family out-of-pocket maximum.
- 3 Telemedicine is provided by a designated telemedicine provider, please visit www.ibx.com/findcarenow.
- 4 Physical Therapy and Occupational Therapy combined visit limit.

Keystone is a Health Maintenance Organization (HMO). This is a managed care program. Coverage is available when your care is provided or referred by a Keystone primary care physician (PCP). Your Keystone PCP may also refer you to other Keystone providers for care, if needed. Designated Site – PCPs are required to choose one radiology, physical therapy, occupational therapy, and laboratory provider where they will send their Keystone members. You can view the sites selected by your PCP at www.ibx.com.

This summary represents only a partial listing of benefits and exclusions of the Medical Program described in this summary. If you purchase another program, the benefits and exclusions may differ. Also, benefits and exclusions may be further defined by medical policy. As a result, this managed care plan may not cover all of your health care expenses. Read your contract/member benefit booklet carefully for a complete listing of terms, limitations, and exclusions of the program. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.ibx.com/IndBooklet or call **1-800-ASK-BLUE** (TTY: 711).

Benefits may be changed by Independence Blue Cross to comply with applicable federal/state laws and regulations.

Certain services require preapproval/precertification by the health plan prior to being performed. To obtain a list of services that require authorization, please log on to <http://www.ibx.com/preapproval> or call the phone number that is listed on the back of your identification card.

Benefits underwritten or administered by Keystone Health Plan East, a subsidiary of Independence Blue Cross - Independent licensees of the Blue Cross and Blue Shield Association. www.ibx.com

Drug Benefit Highlights

Keystone HMO Silver Proactive Rx

Covered Services

Benefits per Calendar Year

Deductible (Embedded) ¹ Individual/Family
Out-of-Pocket Maximum Formulary ²
Dispense as Written (DAW) Provision ³

Retail Pharmacy

Tier 1 Low-Cost Generic Drugs
Tier 2 Generic Drugs
Tier 3 Preferred Brand Drugs
Tier 4 Non-Preferred Drugs
Tier 5 Self-Administered Specialty Drugs
Dispensing Limits ⁴

Mail Order Pharmacy Available for maintenance drugs

Tier 1 Low-Cost Generic Drugs
Tier 2 Generic Drugs
Tier 3 Preferred Brand Drugs
Tier 4 Non-Preferred Drugs
Tier 5 Self-Administered Specialty Drugs
Dispensing Limits ⁵

Drug Coverage

ACA Preventive Drugs
Compound Medications
Contraceptives
Diabetic Supplies (i.e., test strips)
Glucometers
Insulin
Insulin Needles and Syringes
Lancets
Prescribed Tobacco Cessation Drugs (RX and OTC)

Your Costs (You pay)

In-Network	Out-of-Network
------------	----------------

\$300/\$600	\$300/\$600
Combined with Medical Value	Combined with Medical
Mandatory Generic	

In-Network	Out-of-Network
------------	----------------

\$3 no deductible	30% Reimbursement no deductible
\$20 no deductible	30% Reimbursement no deductible
\$100 after deductible	30% Reimbursement after deductible
50% up to \$500 after deductible	30% Reimbursement after deductible
50% up to \$1,000 after deductible	Not covered
30 day supply max	30 day supply max

In-Network	Out-of-Network
------------	----------------

\$6 no deductible	Not covered
\$40 no deductible	Not covered
\$200 after deductible	Not covered
50% up to \$1,000 after deductible	Not covered
Not covered	Not covered
90 day supply max	Not covered

In-Network	Out-of-Network
------------	----------------

Covered	Covered
Covered	Covered
Covered	Covered
Covered	Covered
Covered	Covered
Covered	Covered
Covered	Covered
Covered	Covered
Covered	Covered

Allergy Serum	Not covered	Not covered
Blood, Blood Plasma	Not covered	Not covered
Drugs used for Cosmetic Purposes	Not covered	Not covered
Injectable Fertility Drugs	Not covered	Not covered
Investigational/Experimental Drugs	Not covered	Not covered
Non-Federal Legend Drugs	Not covered	Not covered
Over-The-Counter Drugs (Non-Prescription)	Not covered	Not covered
Weight Control Drugs	Not covered	Not covered

- 1 Embedded deductible: Each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving plan benefits.
- 2 Benefits will be provided for Covered Drugs and medicines appearing on the Drug Formulary. To check the formulary status of a drug or view a copy of the most recent formulary, log onto www.ibx.com.
- 3 When a prescription drug is not available in a generic form, benefits will be provided for the brand drug and you will be responsible for the member cost sharing for a brand drug. When a prescription drug is available in a generic form, benefits will be provided for that drug at the generic drug level only. If you purchase a brand drug, you will be responsible for paying the dispensing pharmacy the difference between the negotiated discount price for the generic drug and the brand drug plus the appropriate member cost sharing for a brand drug.
- 4 Maintenance medications may also be available for up to a 90-day supply at participating Act 207 Retail pharmacies for the same mail order member cost sharing as indicated above.
- 5 Mail order cost-sharing for 1-30 day supplies is equal to the in-network retail cost-sharing. Up to a 90-day supply of drugs to treat chronic conditions also available at Rite Aid.

This summary represents only a partial listing of benefits and exclusions of the Prescription Drug Program described in this summary. If you purchase another program, the benefits and exclusions may differ. Also, benefits and exclusions may be further defined by pharmacy policy. As a result, this program may not cover all of your health care expenses. Read your contract/member benefit booklet carefully for a complete listing of terms, limitations, and exclusions of the program. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.ibx.com/IndBooklet or call **1-800-ASK-BLUE** (TTY: 711).

Certain designated preventative medications will not be subject to any cost-sharing or deductibles, but will be subject to the terms and conditions of your benefits contract. Refer to your summary of benefits, member handbook, and/or benefit booklet to determine if your plan includes 100 percent coverage for in-network preventive services.

Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order are not covered. Devices or supplies except those specifically listed under covered drugs are not covered.

The network required for this plan is the FutureScripts® Preferred Pharmacy Network. The FutureScripts® Preferred Pharmacy Network is a subset of the national retail pharmacy network, including most major chains and local pharmacies except Walgreens. Out-of-Network benefits apply to prescriptions filled at Non-Preferred pharmacies and you must pay the full retail price for your prescription then file a paper claim for reimbursement. FutureScripts® is an independent company providing pharmacy benefit management service.

Benefits underwritten or administered by Keystone Health Plan East, a subsidiary of Independence Blue Cross - Independent licensees of the Blue Cross and Blue Shield Association. www.ibx.com

Vision Benefit Highlights

Pediatric Vision IND HMO Stnd Med \$0

PEDIATRIC BENEFITS

Covered Services (Calendar Year)	Your Costs (You pay)	
Exam	In-Network	Out-of-Network
Routine Eye Exam at Davis Participating Providers (1 exam/year)	No charge	Not covered
Retinal Imaging	\$39	Not covered
Lenses (1 pair/year)	In-Network	Out-of-Network
Single Vision Lenses	No charge	Not covered
Bifocal Lenses	No charge	Not covered
Trifocal Lenses	No charge	Not covered
Lenticular Lenses	No charge	Not covered
Lens Options	In-Network	Out-of-Network
Progressive Lenses - Standard/Premium/Ultra/Ultimate	\$50/\$90/\$140/\$175	Not covered
Polycarbonate Lenses - Single/Multifocal ¹	No charge	Not covered
Digital/Intermediate Lenses	\$30	Not covered
Photochromic Lenses - Single/Multifocal	No charge	Not covered
Photosensitive Lenses - Single/Multifocal	\$65	Not covered
High-Index 1.67 / High-Index 1.74 Lenses	\$55/\$120	Not covered
Blue Light Lenses	\$15	Not covered
Polarized Lenses	\$75	Not covered
Lens Coatings		
Tinted Plastic Lenses	No charge	Not covered
UV-Coated Lenses	No charge	Not covered
Scratch-Resistant Lenses - Single/Multifocal	No charge	Not covered
Scratch-Protection Plan - Single/Multifocal	\$20/\$40	Not covered
Anti-Reflective Coating - Standard/Premium/Ultra/Ultimate	\$35/\$48/\$60/\$85	Not covered
Frames (1 pair/year)	In-Network	Out-of-Network
Collection Fashion Frames	No charge	Not covered
Collection Designer Frames	No charge	Not covered
Collection Premier Frames	No charge	Not covered
Non-Collection Frames	Up to \$150 Allowance	Not covered
Additional Visionworks Frames Option	Up to \$150 Allowance (plus a 20% discount on overage) ²	Not covered

Contact Lenses (in lieu of glasses) (1 pair/year)	In-Network	Out-of-Network
Collection Contact Lenses Evaluation, Fitting & Follow-Up Care	No charge	Not covered
Collection Contact Lenses	Disposable Boxes/ Multipacks: 4 per year Planned Replacement Boxes/ Multipacks: 2 per year	Not covered
Non-Collection Standard Contact Lenses Evaluation, Fitting & Follow-Up Care	Not covered	Not covered
Non-Collection Specialty & Disposable Contact Lenses Evaluation, Fitting & Follow-Up Care	Not covered	Not covered
Non-Collection Contact Lenses	Up to \$150 Allowance	Not covered
Medically-Necessary Contact Lenses ³	No charge	Not covered

- 1 Polycarbonate lenses for dependent children, monocular patients, and patients with prescriptions greater than or equal to +/6.00 diopters are covered at no cost.
- 2 Member is responsible for balance. Additional discounts not applicable at Walmart, Costco, or Sam's Club locations.
- 3 Covered with prior approval.

This summary represents only a partial listing of benefits of the Vision Care Program described in this summary. If you purchase another program, the benefits may differ. Also, benefits may be further defined by the vision policy. As a result, this vision plan may not cover all of your vision or health care expenses. Read your contract/member benefit booklet carefully for a complete listing of terms and limitations of the program. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.ibx.com/IndBooklet or call **1-800-ASK-BLUE** (TTY: 711).

Benefits may be changed by Independence Blue Cross to comply with applicable federal/state laws and regulations.

Administered by Davis Vision.

Benefits underwritten or administered by Keystone Health Plan East, a subsidiary of Independence Blue Cross - Independent licensees of the Blue Cross and Blue Shield Association. www.ibx.com

Dental Benefit Highlights

Pediatric Dental IND HMO

PEDIATRIC BENEFITS

Covered Services	Your Costs (You pay)	
Benefits per Calendar Year	In-Network	Out-of-Network
Annual Plan Maximum	Unlimited	Not covered
Deductible (per child)	\$50	Not covered
Out-of-Pocket Maximum (per child)	Medical out-of-pocket maximum applies.	Not covered
Medically Necessary Orthodontic Maximum (per child)	Unlimited	Not covered
Coverage Type	In-Network	Out-of-Network
Diagnostic & Preventive Services	No charge no deductible	Not covered
Basic Services	50% after deductible	Not covered
Major Services	50% after deductible	Not covered
Medically Necessary Orthodontics	50% after deductible	Not covered
Cosmetic Orthodontic Services	Not covered	Not covered
Key Covered Services	In-Network	Out-of-Network
Exams	No charge no deductible	Not covered
Cleanings	No charge no deductible	Not covered
Bitewing X-rays	50% no deductible	Not covered
Fluoride Treatments	No charge no deductible	Not covered
Sealants	No charge no deductible	Not covered
Basic Restorative (Fillings)	50% after deductible	Not covered
Oral Surgery	50% after deductible	Not covered
Endodontics	50% after deductible	Not covered
Periodontics	50% after deductible	Not covered
Crowns	50% after deductible	Not covered
Bridges	50% after deductible	Not covered
Dentures	50% after deductible	Not covered

This summary represents only a partial listing of benefits of the Dental Plan described in this summary. If you purchase another program, the benefits may differ. Also, benefits may be further defined by dental policy. As a result, this dental plan may not cover all of your dental or health care expenses. Read your contract/member benefit booklet carefully for a complete listing of terms and limitations of the program. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.ibx.com/IndBooklet or call **1-800-ASK-BLUE** (TTY: 711).

Benefits may be changed by Independence Blue Cross to comply with applicable federal/state laws and regulations.

Benefits underwritten or administered by QCC Insurance Company, a subsidiary of Independence Blue Cross - Independent licensees of the Blue Cross and Blue Shield Association. www.ibx.com

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意: 如果您讲中文, 您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કોલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic: ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzsch, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese: 備考: 母国語が日本語の方は、言語アシスタンスサービス (無料) をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi):

توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

Navajo: Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh. Hódííłnih koji' 1-800-275-2583.

Urdu:

توجه درکار ہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583.

Mon-Khmer, Cambodian: សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះ ជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

Discrimination is Against the Law

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

This Plan 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, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This 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 our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscordinator@1901market.com. If you need help filing a grievance, our 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, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.