Brand New Day Classic Care Drug Savings (HMO) offered by Brand New Day

Annual Notice of Changes for 2018

You are currently enrolled as a member of Classic Care. Next year, there will be some changes to the plan's costs and benefits. This booklet tells about the changes.

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 3 and 3.5 for information about benefit and cost changes for our plan.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost-sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2018 Drug List and look in Section 3.6 for information about changes to our drug coverage.

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors in our network?
- What about the hospitals or other providers you use?
- Look in Section 3.3 for information about our Provider Directory.

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ Think about whether you are happy with our plan.

2. **COMPARE:** Learn about other plan choices

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at https://www.medicare.gov website. Click "Find health & drug plans."
- Review the list in the back of your Medicare & You handbook.
- Look in Section 5.2 to learn more about your choices.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE: Decide whether** you want to change your plan

- If you want to **keep** Classic Care, you don't need to do anything. You will stay in Classic Care.
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. **ENROLL:** To change plans, join a plan between **October 15** and **December 7, 2017**

- If you **don't join by December 7, 2017**, you will stay in Classic Care.
- If you **join by December 7, 2017**, your new coverage will start on January 1, 2018.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Member Services number at 1-866-255-4795 for additional information. (TTY users should call 1-866-321-5955.) Hours are 8:00 a.m. to 8:00 p.m. 7 days a week from October 1 – February 14 and 8:00 a.m. to 8:00 p.m. Monday – Friday from February 15 – September 30.
- This information may be available in a different format or language.
- **Coverage under this Plan qualifies as minimum essential coverage (MEC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Brand New Day Classic Care Drug Savings

- Brand New Day is a Medicare Advantage Organization with a Medicare contract. Enrollment in this plan depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Brand New Day. When it says "plan" or "our plan," it means Brand New Day Classic Care Drug Savings.

Summary of Important Costs for 2018

The table below compares the 2017 costs and 2018 costs for Brand New Day Classic Care Drug Savings in several important areas. **Please note this is only a summary of changes**. **It is important to read the rest of this Annual Notice of Changes** and review the enclosed Evidence of Coverage to see if other benefit or cost changes affect you.

Cost	2017 (this year)	2018 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 3.1 for details.	$0	$0
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 3.2 for details.)	$3,400	$3,400
Doctor office visits	Primary care visits: You pay $0 per visit Specialist visits: You pay $0 per visit	Primary care visits: You pay $0 per visit Specialist visits: You pay $0 per visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	You pay $0	You pay $0

Cost	2017 (this year)	2018 (next year)
Part D prescription drug coverage (See Section 3.6 for details.)	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: You pay $0 • Drug Tier 2: You pay a $5 copay • Drug Tier 3: You pay a $45 copay • Drug Tier 4: You pay a $90 copay • Drug Tier 5: You pay 33% of the total cost • Drug Tier 6: You pay an $11 copay	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: You pay $0 • Drug Tier 2: You pay an $8 copay • Drug Tier 3: You pay a $45 copay • Drug Tier 4: You pay a $75 copay • Drug Tier 5: You pay 33% of the total cost • Drug Tier 6: You pay $0

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SECTION 1 We Are Changing the Plan's Name

On January 1, 2018, our plan name will change from Classic Care to Brand New Day Classic Care Drug Savings.

You will receive your Brand New Day ID card by or before January 1st.

SECTION 2 Unless You Choose Another Plan, You Will Be Automatically Enrolled in Brand New Day Classic Care Drug Savings in 2018

If you do nothing to change your Medicare coverage by December 7, 2017, we will automatically enroll you in our Brand New Day Classic Care Drug Savings. This means starting January 1, 2018, you will be getting your medical and prescription drug coverage through Brand New Day Classic Care Drug Savings. If you want to, you can change to a different Medicare health plan. You can also switch to Original Medicare. If you want to change, you must do so between October 15 and December 7. If you are eligible for Low Income Subsidies, you can change plans at any time.

The information in this document tells you about the differences between your current benefits in Classic Care and the benefits you will have on January 1, 2018 as a member of Brand New Day Classic Care Drug Savings.

SECTION 3 Changes to Benefits and Costs for Next Year

Section 3.1 – Changes to the Monthly Premium

Cost	2017 (this year)	2018 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	$0

- Your monthly plan premium will be more if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more, if you enroll in Medicare prescription drug coverage in the future.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be less if you are receiving "Extra Help" with your prescription drug costs.

Section 3.2 – Changes to Your Maximum Out-of-Pocket Amount

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. This limit is called the "maximum out-of-pocket amount." Once you reach this amount, you generally pay nothing for covered services for the rest of the year.

Cost	2017 (this year)	2018 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$3,400	$3,400 Once you have paid $3,400 out-of-pocket for covered services, you will pay nothing for your covered services for the rest of the calendar year.

Section 3.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated Provider Directory is located on our website at www.bndhmo.com. You may also call Member Services for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2018 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.

- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider and managing your care.

Section 3.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

There are changes to our network of pharmacies for next year. An updated Pharmacy Directory is located on our website at www.bndhmo.com. You may also call Member Services for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2018 Pharmacy Directory to see which pharmacies are in our network**.

Section 3.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, Medical Benefits Chart (what is covered and what you pay), in your 2018 Evidence of Coverage.

Cost	2017 (this year)	2018 (next year)
Emergency Care	You pay a $75 copay per visit	You pay a $100 copay per visit
Partial hospitalization	You pay $0	You pay 20% of the total cost
Occupational therapy services	You pay $0	You pay a $5 copay per visit
Physical therapy and speech and language therapy services	You pay 20% of the total cost	You pay a $5 copay per visit

Cost	2017 (this year)	2018 (next year)
Outpatient hospital services	You pay $0	You pay $0 for surgery You pay 20% of the total cost for all other outpatient hospital services
Ambulance	You pay a $100 copay per trip	You pay a $125 copay per trip
Acupuncture and other alternative therapies	You pay a $5 copay per treatment	You pay $0
Over the Counter (OTC) Items and Services	$20 maximum benefit amount per month	$100 maximum benefit amount every three months. Scale and/or blood pressure cuff will be provided at no cost to members with chronic heart failure or liver disease.
Routine eyewear	Maximum benefit amount of $250 every two years for one (1) set of routine eyeglasses every two years.	Maximum benefit amount of $300 every two years for one (1) set of routine eyeglasses every two years.
Hearing exams	You pay 20% of the total cost	You pay $0

Section 3.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is in this envelope. The Drug List we included in this envelope includes many –but not all– of the drugs that we will cover next year. If you don't see your drug on this list, it might still be covered. **You**

can get the complete Drug List by calling Member Services (see the back cover) or visiting our website www.bndhmo.com.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug.
    - To learn what you must do to ask for an exception, see Chapter 9 of your Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) or call Member Services.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Member Services to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a **one-time**, temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the Evidence of Coverage.) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

Formulary exceptions that have been approved for 2018 will be covered to the expiration date in 2018. You do not need to ask for another one. Some formulary exceptions may change in 2018, and you will not need to ask for an exception. Before the end of the expiration date stated in the approval letter, call member services for assistance.

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We have included a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you receive "Extra Help" and didn't receive this insert with this packet, please call Member Services and ask for the "LIS Rider." Phone numbers for Member Services are in Section 9.1 of this booklet.

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your Evidence of Coverage for more information about the stages.)

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the enclosed Evidence of Coverage.)

Changes to the Deductible Stage

Stage	2017 (this year)	2018 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost-sharing in the Initial Coverage Stage

Please see the following chart for the changes from 2017 to 2018.

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, Types of out-of-pocket costs you may pay for covered drugs in your Evidence of Coverage.

Stage	2017 (this year)	2018 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost-sharing. For information about the costs for a long-term supply, or for mail-order prescriptions, look in Chapter 6, Section 5 of your Evidence of Coverage. **We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.**	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Tier 1: – Preferred Generic:** You pay $0 per prescription **Tier 2 –Generic:** You pay a $5 copay per prescription **Tier 3 – Preferred Brand:** You pay a $45 copay per prescription **Tier 4 – Non-Preferred Brand:** You pay a $90 copay per prescription **Tier 5 – Specialty Drugs:** You pay 33% of the total cost. **Tier :6 – Select Diabetic Drugs:** You pay an $11 copay per prescription _____ Once your total drug costs have reached $3,700 you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Tier 1: – Preferred Generic:** You pay $0 per prescription **Tier 2 –Generic:** You pay an $8 copay per prescription **Tier 3 – Preferred Brand:** You pay a $45 copay per prescription **Tier 4 – Non-Preferred Drug:** You pay a $75 copay per prescription **Tier 5 – Specialty Drugs:** You pay 33% of the total cost. **Tier :6 – Select Care Drugs:** You pay $0 per prescription _____ Once your total drug costs have reached $3,750 you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your Evidence of Coverage.

SECTION 4 Administrative Changes

	2017 (this year)	2018 (next year)
Website change	www.brandnewdayhmo.com	www.bndhmo.com
Name of Tier 4	Tier 4: Non-Preferred Brand	Tier 4: Non-Preferred Drug
Name of Tier 5	Tier 5: Specialty Drugs	Tier 5: Specialty Tier
Name of Tier 6	Tier 6: Select Diabetic Drugs	Tier 6: Select Care Drugs
Referral is now required		Medicare covered preventive services

SECTION 5 Deciding Which Plan to Choose

Section 5.1 – If you want to stay in Brand New Day Classic Care Drug Savings

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically stay enrolled as a member of our plan for 2018.

Section 5.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2018 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- OR-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, read Medicare & You 2018, call your State Health Insurance Assistance Program (see Section 7), or call Medicare (see Section 9.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to https://www.medicare.gov and click "Find health & drug plans." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, Brand New Day offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Brand New Day Classic Care Drug Savings.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Brand New Day Classic Care Drug Savings.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are in Section 9.1 of this booklet).
    - – or – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 6 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2018.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area are allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the Evidence of Coverage.

If you enrolled in a Medicare Advantage plan for January 1, 2018, and don't like your plan choice, you can switch to Original Medicare between January 1 and February 14, 2018. For more information, see Chapter 10, Section 2.2 of the Evidence of Coverage.

SECTION 7 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In California, the SHIP is called Health Insurance Counseling Advocacy Program (HICAP).

HICAP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. HICAP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call HICAP at 1-800-434-0222. You can learn more about HICAP by visiting their website: www.aging.ca.gov/hicap/

SECTION 8 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or pate enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
    - Your State Medicaid Office (applications).

Prescription Cost-sharing Assistance for Persons with HIV/AIDS. The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through Magellan Rx Management, contractor for Pharmacy/Medication Benefits for ADAP (telephone number: 1-800-424-5906). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the California Department of Public Health (CDPH), ADAP Toll Free, Phone Number: 1-844-421-7050.

SECTION 9 Questions?

Section 9.1 – Getting Help from Brand New Day Classic Care Drug Savings

Questions? We're here to help. Please call Member Services at 1-866-255-4795. (TTY only, call 1-866-321-5955. We are available for phone calls:

- October 1 – February 14: 7 days a week, 8:00 a.m. – 8:00 p.m.
- February 15 – September 30: Monday – Friday, 8:00 a.m. – 8:00 p.m.

Calls to these numbers are free.

Read your 2018 Evidence of Coverage (it has details about next year's benefits and costs)

This Annual Notice of Changes gives you a summary of changes in your benefits and costs for 2018. For details, look in the 2018 Evidence of Coverage for Brand New Day Classic Care Drug Savings. The Evidence of Coverage is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the Evidence of Coverage is included in this envelope.

Visit our Website

You can also visit our website at www.bndhmo.com. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

Section 9.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (https://www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to https://www.medicare.gov and click on "Find health & drug plans").

Read Medicare & You 2018

You can read the Medicare & You 2018 Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (https://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

NOTICE OF NON-DISCRIMINATION

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

Brand New Day 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)

Brand New Day also 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 the Brand New Day, Customer Service Department at: 1-866-255-4795 (TTY -866-321-5955). Hours are: October 1 – February 14: 7 days a week, 8:00 a.m. – 8:00 p.m. February 15 – September 30: Monday – Friday, 8:00 a.m. – 8:00 p.m.

If you believe that Brand New Day 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 by calling our Customer Service Department or mailing a letter to:

Brand New Day Appeals and Grievances Department
Attn: A&G Manager
5455 Garden Grove Blvd, Suite 500
Westminster, California 92683
Fax: 657-400-1217
Email: Complaints@universalcare.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Customer Service Department 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 available at http://www.hhs.gov/ocr/office/file/index.html