* Your First Name: **Emily** * Your Last Name: **Prince**

Phone:

Phone Number	Usage
[redacted]	[redacted]

Street Address Line 1:* [redacted]

Street Address Line 2: [redacted]

* City: [redacted]

* State[redacted] Country:**USA** * ZIP: [redacted] Email Address (If available): [redacted]

Are you filing this complaint for someone else?: **No**

*** I believe that I have been (or someone else has been) discriminated against on the basis of::**

Sex
Other (specify)

If Other, please specify:: **Gender Identity**

Who or what agency or organization do you believe discriminated against you (or someone else)?

* Person or Agency/Organization?: **Agency/Organization**

Agency/Organization: **CareFirst**

* Street Address Line 1: **840 First Street, NE**

Street Address Line 2: **Union Center Plaza**

* City: **Washington**

* State:**District Of Columbia** Country:**USA** ZIP: **20005**

ZIP:

Phone Number	Usage
(202) 479-8000	Work

*** When do you believe that the civil right discrimination occurred?**

Date(s) Selected:

Violation Date
11/30/2014

Describe briefly what happened. How and why do you believe that you have been (or someone else has been) discriminated against? Please be as specific as possible.. (Attach additional pages as needed)

In a telephone conversation concerning enrollment in Affordable Care Act plans held on November 30, 2014 at 9:45 a.m. Eastern, I asked CareFirst if they discriminated on the basis of gender identity; specifically, did their plans exclude coverage for "services, drugs, or supplies related to sex transformations" [as they do for Federal employees; see plan code 2G]. The attached audio was their response.

"Commonwealth of Virginia, OK. For transgender surgery, it's not going to be covered. [audio cut where I ask about hormone replacement therapy] Hormone replacement therapy? [I respond "Yes Ma'am"] [long pause] It's not going to be; hormone replacement is a, that's not going to be covered either. Anything that's going to be related to that transgender, it's not going to be covered."

Filing a complaint with OCR is voluntary. However, without the information requested above, OCR may be unable to proceed with your complaint. We collect this information under authority of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 and other civil rights statutes. We will use the information you provide to determine if we have jurisdiction and, if so, how we will process your complaint. Information submitted on this form is treated confidentially and is protected under the provisions of the Privacy Act of 1974. Names or other identifying information about individuals are disclosed when it is necessary for investigation of possible discrimination, for internal systems operations, or for routine uses, which include disclosure of information outside the Department of Health and Human Services (HHS) for purposes associated with civil rights compliance and as permitted by law. It is illegal for a recipient of Federal financial assistance from HHS to intimidate, threaten, coerce, or discriminate or retaliate against you for filing this complaint or for taking any other action to enforce your rights under Federal civil rights laws.

You are not required to use this format. You may write a letter or mail a complaint with the same information. To mail a complaint, please send to HHS Office for Civil Rights, Central Intake Unit, 200 Independence Avenue, S.W., Room 509 F,

Washington, D.C. 20201.

*** Signature:** **AGREE: I have read, understand, and agree to the above.**

Do you need special accommodations for us to communicate with you about this complaint?

No entries

If we cannot reach you directly, is there someone we can contact to help us reach you?

No entries

Have you filed your complaint anywhere else? If so, please provide the following . (Attach additional pages as needed)

Filed Elsewheres:

Person/Agency/Organization/Court Name	Date Filed	Case Number (If known)
No records found		

To help us better serve the public, please provide the following information for the person you believe was discriminated against (you or the person on whose behalf you are filing).

Ethnicity: Not Hispanic or Latino

Race: **White**

Primary Language Spoken (if other than English):

How did you learn about the Office for Civil Rights?

HHS Website/Internet Search
Lawyer/Legal Org
Fed/State/Local Gov
Conference/OCR Brochure
Other (specify)

Please specify: Office of Civil Rights Request for Information

concerning §1557

COMPLAINANT CONSENT FORM

The Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) has the authority to collect and receive material and information about you, including personnel and medical records, which are relevant to its investigation of your complaint.

To investigate your complaint, OCR may need to reveal your identity or identifying information about you to persons at the entity or agency under investigation or to other persons, agencies, or entities.

The Privacy Act of 1974 protects certain federal records that contain personally identifiable information about you and, with your consent, allows OCR to use your name or other personal information, if necessary, to investigate your complaint.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

Additionally, OCR may disclose information, including medical records and other personal information, which it has gathered during the course of its investigation in order to comply with a request under the Freedom of Information Act (FOIA) and may refer your complaint to another appropriate agency.

Under FOIA, OCR may be required to release information regarding the investigation of your complaint; however, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

Please read and review the documents entitled, Notice to Complainants and Other Individuals Asked to Supply Information to the Office for Civil Rights and Protecting Personal Informations in Complaint Investigations for further information regarding how OCR may obtain, use, and disclose your information while investigating your complaint.

In order to expedite the investigation of your complaint if it is accepted by OCR, please read, sign, and returnone copy of this consent form to OCR with your complaint. Please make one copy for your records.

- As a complainant, I understand that in the course of the investigation of my

complaint it may become necessary for OCR to reveal my identity or identifying information about me to persons at the entity or agency under investigation or to other persons, agencies, or entities.

- I am also aware of the obligations of OCR to honor requests under the Freedom of Information Act (FOIA). I understand that it may be necessary for OCR to disclose information, including personally identifying information, which it has gathered as part of its investigation of my complaint.
- In addition, I understand that as a complainant I am covered by theDepartment of Health and Human Services' (HHS) regulations which protect any individual from being intimidated, threatened, coerced, retaliated against,or discriminated against because he/she has made a complaint, testified, assisted, or participated in any manner in any mediation, investigation, hearing, proceeding, or other part of HHS' investigation, conciliation, or enforcement process.

*** Consent Selection:**

CONSENT: I have read, understand, and agree to the above and give permission to OCR to reveal my identity or identifying information about me in my case file to persons at the entity or agency under investigation or to other relevant persons, agencies, or entities during any part of HHS' investigation, conciliation, or enforcement process.

File Uploaded:

File Name	Size (Byte)	File Type
CareFirst Discriminates on Basis of Gender Identity.mp3.zip	408342	Complaint Description