




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, call 1-800-240-6430 or at www.bcbstx.com. 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 www.healthcare.gov/sbc-glossary or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For <u>In-Network</u> : EE Only \$400/ EE+Spouse \$800/ EE+ Child(ren) \$1,200/ EE+ Family \$1,200	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Services that charge a <u>copay</u> , <u>prescription drugs</u> , and certain <u>preventive care</u> , <u>diagnostic test</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. Per occurrence: \$250 <u>In-Network</u> inpatient admission. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the out-of-pocket limit for this plan?	For <u>In-Network</u> : EE Only \$2,000/ EE+Spouse \$4,000/ EE+ Child(ren) \$6,000/ EE+ Family \$6,000	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, <u>preauthorization</u> penalties, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.bcbstx.com or call 1-800-240-6430 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>In-Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$35 <u>copay</u> /visit; <u>deductible</u> does not apply	Not Covered	Virtual visits are available, please refer to your <u>plan</u> policy for more details.
	<u>Specialist</u> visit	\$50 <u>copay</u> /visit; <u>deductible</u> does not apply	Not Covered	None
	<u>Preventive care/screening/immunization</u>	No Charge; <u>deductible</u> does not apply	Not Covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	Not Covered	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	Not Covered	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at 855.305.3028	Generic drugs	Preventive Generics Retail: \$10; Mail: \$20 All Other Generics Retail: 15% (\$10 min/ \$50 max); Mail: \$25	Difference between discounted and non-discounted cost PLUS 15% (\$20 min/ \$60 max) <u>coinsurance</u>	Covers up to a 30-day supply (retail), up to 90-day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. Your cost will be higher for choosing Brand over Generics.
	Preferred brand drugs	Retail: 20% (\$25 min/ \$100 max) Mail: \$68	Difference between discounted and non-discounted cost PLUS 20% (\$50 min/ \$125 max) <u>coinsurance</u>	Maintenance drugs- after two (2) retail fills, members are required to fill a 90-day supply at Mail or CVS Retail Pharmacies, otherwise, higher costs may apply.
	Non-preferred brand drugs	Retail: 30% (\$50min/ \$200 max) Mail: \$125	Difference between discounted and non-discounted cost PLUS 30% (\$100 min/ \$250 max) <u>coinsurance</u>	Preventive medications for designated list of drugs and conditions may bypass <u>deductible</u> and receive applicable cost share noted under "Preventive Drugs."
	<u>Specialty drugs</u>	\$0 <u>copay</u> if enrolled in PrudentRx; if not enrolled is 30% <u>coinsurance</u>		No charge for preferred generic FDA-approved women's contraceptives <u>in-network</u> .

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	Not Covered	None
	Physician/surgeon fees	10% <u>coinsurance</u>	Not Covered	None
If you need immediate medical attention	<u>Emergency room care</u>	\$150 <u>copay</u> /visit plus 10% <u>coinsurance</u> ; <u>deductible</u> does not apply	\$150 <u>copay</u> /visit plus 10% <u>coinsurance</u> ; <u>deductible</u> does not apply	<u>Emergency room copay</u> waived if admitted.
	<u>Emergency medical transportation</u>	No Charge; <u>deductible</u> does not apply	No Charge; <u>deductible</u> does not apply	Ground and air transportation covered.
	<u>Urgent care</u>	\$75 <u>copay</u> /visit; <u>deductible</u> does not apply	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	Not Covered	\$250 inpatient admission <u>deductible</u> for <u>In-Network providers</u> . <u>Preauthorization</u> is required.
	Physician/surgeon fees	10% <u>coinsurance</u>	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$35 <u>copay</u> /office visit; <u>deductible</u> does not apply 10% <u>coinsurance</u> for other outpatient services	Not Covered	Certain services must be preauthorized; refer to your benefit* booklet for details. Virtual visits are available, please refer to your <u>plan</u> policy for more details.
	Inpatient services	10% <u>coinsurance</u>	Not Covered	\$250 inpatient admission <u>deductible</u> for <u>In-Network providers</u> . <u>Preauthorization</u> is required.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	\$35 <u>copay</u> /visit; <u>deductible</u> does not apply	Not Covered	<u>Copay</u> applies to first prenatal visit (per pregnancy). <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% <u>coinsurance</u>	Not Covered	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	Not Covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> is required. Limited to 100 visits per calendar year.
	<u>Rehabilitation services</u>	\$35 PCP/\$50 SPC <u>copay</u> /visit; <u>deductible</u> does not apply 10% <u>coinsurance</u> for other outpatient services	Not Covered	Limited to 60 visits combined for all therapies per calendar year. Includes, but is not limited to, occupational, physical, and speech therapy.
	<u>Habilitation services</u>	\$35 PCP/\$50 SPC <u>copay</u> /visit; <u>deductible</u> does not apply 10% <u>coinsurance</u> for other outpatient services	Not Covered	
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> is required. Limited to 100 days per calendar year.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	Not Covered	None
	<u>Hospice services</u>	10% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> is required.
If your child needs dental or eye care	Children's eye exam	No Charge; <u>deductible</u> does not apply	Not Covered	1 routine eye exam per calendar year.
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Long term care
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care (Limited to 20 visits maximum per calendar year)
- Dental care (Adult & child)
- Hearing aids (limited to 1 aid per ear per 36-month period, \$3,000 benefit maximum every 36 months)
- Infertility treatment (All diagnoses are eligible, artificial insemination (All) with a lifetime max of \$10,000)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (Limited to 70 visits maximum per calendar year)
- Routine eye care (Adult, limited to 1 routine eye exam per calendar year)

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: the [plan](#) at 1-800-240-6430, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 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: Blue Cross and Blue Shield of Texas at 1-800-240-6430 or visit www.bcbstx.com, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your [appeal](#). Contact the Texas Department of Insurance's Consumer Health Assistance Program at 1-800-252-3439 or visit www.texashealthoptions.com.

Does this [plan](#) provide [Minimum Essential Coverage](#)? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this [plan](#) meet the [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:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-240-6430.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-240-6430.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-240-6430.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-240-6430.

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.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$400
■ <u>Specialist</u> copayment	\$50
■ Hospital (facility) both	\$250+10%
■ Other <u>coinsurance</u>	10%

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	\$12,700
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u> *	\$650
<u>Copayments</u>	\$50
<u>Coinsurance</u>	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,960

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The <u>plan's</u> overall <u>deductible</u>	\$400
■ <u>Specialist</u> copayment	\$50
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

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	\$5,600
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$400
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$700
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,620

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$400
■ <u>Specialist</u> copayment	\$50
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

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	\$2,800
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$400
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$40
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$840

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The plan would be responsible for the other costs of these EXAMPLE covered services.



BlueCross BlueShield of Texas

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To speak to an interpreter, call the customer service number on the back of your member card. If you are not a member, or don't have a card, call 855-710-6984.

العربية Arabic	إن كان لديك أو لدى شخص تساعدك أسئلة، ف لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث إلى مترجم فوري، اتصل على رقم خدمة العملاء المذكور على ظهر بطاقة عضويتك. فإن لم تكن عضوًا، أو كنت لا تملك بطاقة، فاتصل على 855-710-6984.
繁體中文 Chinese	如果您，或您正在協助的對象，對此有疑問，您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員，請致電印在您的會員卡背面的客戶服務電話號碼。如果您不是會員，或沒有會員卡，請致電 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, composez le numéro du service client indiqué au verso de votre carte de membre. Si vous n'êtes pas membre ou si vous n'avez pas de carte, veuillez composer le 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Kundenservicenummer auf der Rückseite Ihrer Mitgliedskarte an. Falls Sie kein Mitglied sind oder keine Mitgliedskarte besitzen, rufen Sie bitte 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. દુભાષિયા સાથે વાત કરવા માટે, તમારા સભ્યપદના કાર્ડની પાછળ આપેલ ગ્રાહક સેવા નંબર પર કોલ કરો. જો આપ સભ્યપદ ના ધરાવતા હોવ, અથવા આપની પાસે કાર્ડ નથી તો 855-710-6984 નંબર પર કોલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए, अपने सदस्य कार्ड के पीछे दिए गए ग्राहक सेवा नंबर पर कॉल करें। यदि आप सदस्य नहीं हैं, या आपके पास कार्ड नहीं है, तो 855-710-6984 पर कॉल करें।
日本語 Japanese	ご本人様、またはお客様の身の回りの方でも、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。料金はかかりません。通訳とお話される場合、メンバーカードの裏のカスタマーサービス番号までお電話ください。メンバーでない場合またはカードをお持ちでない場合は 855-710-6984 までお電話ください。
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 회원 카드 뒷면에 있는 고객 서비스 번호로 전화하십시오. 회원이 아니시거나 카드가 없으시면 855-710-6984 으로 전화하십시오.
ລາວ Laotian	ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອມີຄຳຖາມ, ທ່ານມີສິດຂໍອໍານວຍການຊ່ວຍເຫຼືອ ແລະ ຂໍມູນເປັນພາສາຂອງທ່ານໄດ້ໃດໆບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຕົວກັບພາຍແພດພາສາ, ໃຫ້ໃບຫາດັບຜ່ານບໍລິການລູກຄ້າທີ່ມີຄູ່ຕົວບັງບັດສະມາຊິກຂອງທ່ານ. ຖ້າທ່ານບໍ່ແມ່ນສະມາຊິກ, ຫຼື ບໍ່ມີບັດ, ໃຫ້ໃບຫາດັບ 855-710-6984.
Diné Navajo	T'áá ni, éí doodago la'da biká anánílwo'ígíí, na'idílkidgo, ts'idá bee ná ahóótí'i' t'áá nílk'e níká a'doolwol. Ata' halne'í bich'i' hadeesdzih nínízingo éí kwe'é da'iníishgi áká anídaalwo'ígíí bich'i' hodíílnih, bee nééhózinii bine'déé' bikáá'. Kojí atah naaltsoos ná hadít'écégoó éí doodago bee nééhózinígíí ádingo kojí' hodíílnih 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سوآلی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با خدمات مشتری به شماره ای که در پشت کارت عضویت شما درج شده است تماس بگیرید. اگر عضو نیستید، یا کارت عضویت ندارید، با شماره 855-710-6984 تماس حاصل نمایید.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы поговорить с переводчиком, позвоните в отдел обслуживания клиентов по телефону, указанному на обратной стороне вашей карточки участника. Если вы не являетесь участником или у вас нет карточки, позвоните по телефону 855-710-6984.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete comuníquese con el número del Servicio al Cliente que figura en el reverso de su tarjeta de miembro. Si usted no es miembro o no posee una tarjeta, llame al 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa numero ng serbisyo para sa kustomer sa likod ng iyong kard ng miyembro. Kung ikaw ay hindi isang miyembro, o kaya ay walang kard, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کر رہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، کسٹمر سروس نمبر پر کال کریں جو آپ کے کارڈ کی پشت پر درج ہے۔ اگر آپ ممبر نہیں ہیں، یا آپ کے پاس کارڈ نہیں ہے تو، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị hoặc người mà quý vị giúp đỡ có bất kỳ câu hỏi nào, quý vị có quyền được hỗ trợ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, gọi số dịch vụ khách hàng nằm ở phía sau thẻ hội viên của quý vị. Nếu quý vị không phải là hội viên hoặc không có thẻ, gọi số 855-710-6984.

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a [grievance](#).

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, IL 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
Complaint Forms: <http://www.hhs.gov/ocr/office/file/index.html>