



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, visit [www.bcbstx.com](http://www.bcbstx.com) or by calling 1-855-357-5228. 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 <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/> or call 1-800-456-5974 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	In-Network: \$300 Individual / \$900 Family Out-of-Network: \$600 Individual / \$1,800 Family	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> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. Services that charge a <u>copay</u> , <u>prescription</u> drugs, and <u>In-Network</u> <u>diagnostic tests</u> , <u>home</u> <u>health</u> , <u>skilled nursing</u> , and <u>hospice</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.
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet deductibles for specific services.
<b>What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u>?</b>	In-Network: \$1,800 Individual / \$5,400 Family Out-of-Network: \$4,200 Individual / \$12,600 Family	The <u>out-of-pocket</u> <u>limit</u> is the most you could pay in a year for covered services.
<b>What is not included in the <u>out-of-pocket</u> <u>limit</u>?</b>	<u>Deductible</u> , <u>premiums</u> , <u>preauthorization</u> penalties, <u>balance-billed</u> charges, 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</u> <u>limit</u> .
<b>Will you pay less if you use a <u>network</u> <u>provider</u>?</b>	Yes. See <a href="http://www.bcbstx.com">www.bcbstx.com</a> or call 1-855-357-5228 for a list of <u>In-Network</u> providers.	This plan uses a <u>provider</u> <u>network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's</u> <u>network</u> . You will pay the most if you use an <u>out-of-network</u> <u>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 plan pays ( <u>balance billing</u> ). Be aware your <u>network</u> <u>provider</u> might use an <u>out-of-network</u> <u>provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$30 <u>copay</u> /visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	Virtual visits available through MDLive \$0 <u>copay</u> . In-Network.
	<u>Specialist</u> visit	\$30 <u>copay</u> /visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	\$30 <u>copay</u> /visit; <u>deductible</u> does not apply.	30% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your <u>plan</u> will pay for. No Charge for immunizations <u>In-and-Out-of-Network</u> through the 6 <sup>th</sup> birthday. After the 6 <sup>th</sup> birthday, office <u>copay</u> applies <u>In-Network</u> and <u>deductible</u> only applies <u>Out-Of-Network</u> .
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	No Charge; <u>deductible</u> does not apply	30% <u>coinsurance</u>	Office visit <u>copay</u> may apply.
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
<b>If you need drugs to treat your illness or condition</b> More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.mybenefits.org">www.mybenefits.org</a>	Tier 1	Retail: \$10 <u>copay</u> / prescription Mail: \$20 <u>copay</u> / prescription; <u>deductible</u> does not apply	Total Cost of prescription	Retail: one <u>copay</u> per 30-day supply Retail -90: two copays up to 90 day supply Mail: two <u>copays</u> up to 90-day supply. Members electing to purchase brand name drugs when a generic is available will be required to pay the difference between the cost of the Generic drug and Brand Name drug, plus the Brand Name <u>Copayment</u> .
	Tier 2	Retail: \$30 <u>copay</u> / prescription Mail: \$60 <u>copay</u> / prescription; <u>deductible</u> does not apply	Total Cost of prescription	
	Tier 3	Retail: \$45 <u>copay</u> / prescription Mail: \$90 <u>copay</u> / prescription; <u>deductible</u> does not apply	Total Cost of prescription	



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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Specialty drugs</u>	\$30 / \$45 <u>copay</u> / prescription; <u>deductible</u> does not apply	Total Cost of prescription	<u>Specialty drug</u> prescriptions must be filled through Lumicera Specialty Pharmacy. One <u>copay</u> per 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	10% <u>coinsurance</u> after \$90 <u>copay</u> /visit	10% <u>coinsurance</u> after \$90 <u>copay</u> /visit	Copay waived if admitted.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Subject to mileage pricing.
	<u>Urgent care</u>	\$30 <u>copay</u> /visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	All services must be preauthorized; \$250 penalty applies. <u>Out-of-Network</u> for failure to preauthorize.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <u>copay</u> / office visit; <u>deductible</u> does not apply 10% <u>coinsurance</u> for other outpatient services	30% <u>coinsurance</u> office visit 30% <u>coinsurance</u> for other outpatient services	Certain services must be preauthorized; refer to benefit booklet for details.
	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	All services must be preauthorized; \$250 penalty applies <u>Out-of-Network</u> for failure to preauthorize.
If you are pregnant	Office visits	\$30 <u>copay</u> / initial visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	10% <u>coinsurance</u> applies after initial visit In-Network.



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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Cost sharing does not apply for preventive services. 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 facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	All services must be preauthorized; \$250 penalty applies <u>Out-of-Network</u> for failure to preauthorize.
If you need help recovering or have other special health needs	<u>Home health care</u>	No Charge; <u>deductible</u> does not apply	30% <u>coinsurance</u>	Limited to 60 visits per <u>plan</u> year. All services must be preauthorized.
	<u>Rehabilitation services</u>	\$30 <u>copay</u> / visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
	<u>Habilitation services</u>	\$30 <u>copay</u> / visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
	<u>Skilled nursing care</u>	No Charge; <u>deductible</u> does not apply	30% <u>coinsurance</u>	Limited to 25 days per plan year. All services must be preauthorized.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Hospice services</u>	No Charge; <u>deductible</u> does not apply	30% <u>coinsurance</u>	All services must be preauthorized.
If your child needs dental or eye care	Children's eye exam	\$30 <u>copay</u> / visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
	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         | • Hearing Aids          | • Private-duty nursing |
| • Bariatric surgery   | • Infertility treatment | • Routine foot care    |
| • Cosmetic surgery    | • Long-term care        | • Weight loss programs |
| • Dental care (Adult) |                         |                        |

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

- |                     |   |                            |
|---------------------|---|----------------------------|
| • Chiropractic care | • Non-emergency care when traveling<br>Outside the U.S. | • Routine eye care (Adult) |
|---------------------|---|----------------------------|

**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 1-855-357-5228, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](http://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](http://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 on how 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 Blue Shield of Texas at 1-855-357-5228 or visit [www.bcbstx.com](http://www.bcbstx.com), or contact the U.S. Department of Labor's Employee Benefits Security Administrations at 1-866-444-EBSA (3272) or visit [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Contact the Texas Department of Insurance at 1-800-252-3439 or visit [www.texashealthoptions.com](http://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 1-855-357-5228.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-357-5228.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-357-5228.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-357-5228.]

*To see examples of how the 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 plan's overall deductible	\$300
■ Specialist copayment	\$30
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$300
Copayments	\$200
Coinsurance	\$2,200
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,760</b>

### Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$300
■ Specialist copayment	\$30
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$300
Copayments	\$1,100
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,760</b>

### Mia's Simple Fracture

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

■ The plan's overall deductible	\$300
■ Specialist copayment	\$30
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$300
Copayments	\$500
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,000</b>

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

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.

تغيرعلا Arabic	نا ناك ائيدل وَا ندل صخش هدعاست ائتلسا، لئيدلف قجحا في لوصلحا على قداعسما تاملوعملوا تيروورضلّا لغتلغل نم نوذ مّيا تكلفة. ئثحتال. إبلّا مجرت يروف لصتا على مقرّ أمدح ءلامعلا روكنملا على ريهظ تقاطب لكثيوضع. نإف لم نكت عضواً، وأ نتك لا اكلمت تقاطب، لصتاف 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 છો એવી કોઈ બીજા વ્યક્તિને એસ.બી.એમ. નું ભાષિય સ્થળે 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.
हंद Hindi	यदि आपके, या आप जिसका सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में हमसे शुरुआत 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 있는고객 서비스 번호로 전화하십시오. 회원이 아니거나 카드가 없으시면 855-710-6984 으로 전화하십시오.
ລາວ Laotian	ຖ້າ ທ່ານ ຫຼື ຄົນ ໃກ້ຄູ່ ຂອງທ່ານ ບໍ່ເຂົ້າໃຈ ການບໍລິການ ຫຼື ພະນັກງານ ຂອງພວກເຮົາ ນັ້ນ ທ່ານມີສິດຕິດອາການ ດາວ ອາໄຫຼ່ ພາສາຂອງທ່ານ ເພື່ອ ໂດຍບໍ່ມີຄ່າ ຈ່າ ພາສາ ອື່ນ ມາ ບາດແປ ພາສາ, ໃຫ້ ໂທຫາ ຕື່ມ ພາສາ ຂອງທ່ານ ຫຼື ພາສາ ຂອງທ່ານ ບໍ່ມີຄ່າ ຈ່າ ໂທຫາ ຕື່ມ 855-710-6984.
Diné Navajo	T’lɪni, 47 doodago [a’də b7k1 anɪn7wo’7g77, na’7d7[kidgo, ts’7d1 bee n1 ah00ti’i’ t’lɪn77k’e n7k1 a’ doolwo]. Ata’ halne’7 bich’8’ haadeesdzih n7n7zingo 47 kwe’4 da’7n7ishgi 1k1 an7daalwo’7g77 bich’8’ hod77lnih, bee n44h0zinii bine’ d66’ bik1ɪ’. Koj7 atah naaltsoos n1 had7t’44g00 47 doodago bee n44h0zin7g77 1dingo koj8’ hod77lnih 855-710-6984.
یسرائیل Persian	لصاح دييمانز رگا امش، به شما كه کسی یا او می کمک دینک، یلاؤس متشاد دیشاب، قدنیا ار دیراد به که نابز دوخ، به روطن لیگار کمک و تعا علاطا تغایرد دییمانز تهجد وگفتگ یک با مجرتم ی هاشف، با تامندخ يرتشم به هرامش یا که رد تشپ تراک تیوضع شما جرد هندش تسا سامد دیریگی. رگا وضد دیتسین، یا تراک تیوضع دیراند، هراشم یا 855-710-6984 سامد
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.
ودرا Urdu	رگ یا وک، کسی یا عسیا درف وک سچ کی یا دم ع برک ریہ، ی نوک لاوس شیرد بی وت یا وک ی نیان باز ریہ تمھ دم روا تا مولع لصاح ع نزک کا قد ع مجرتم سے تاب ع نزک کے یلے، رمشک سورس ربمز دل اک ریڑک وج یا کے ڈراکی تشپ رپ جرد ع رگا یا ربم ریڈ ریہ، یا پا کے ساپ ڈراک ریڈ بی وت 855-710-6984 رپ لاک ریڑک
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 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, Illinois 60601

Phone: 855-664-7270 (voicemail)  
TTY/TDD: 855-661-6965  
Fax: 855-661-6960  
Email: [CivilRightsCoordinator@hcsc.net](mailto: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 Phone: 800-368-1019  
200 Independence Avenue SW TTY/TDD: 800-537-7697  
Room 509F, HHH Building 1019 Complaint Portal: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>  
Washington, DC 20201 Complaint Forms: <http://www.hhs.gov/ocr/office/file/index.html>