The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 <u>www.bcbstx.com</u> or by calling 1-855-357-5228. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> 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:
What is the overall <u>deductible</u> ?	<u>In-Network</u> : \$1,000 Individual / \$3,000 Family <u>Out-of-Network</u> : \$3,000 Individual / \$9,000 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> .
Are there services covered before you meet your <u>deductible?</u>	Yes. Services that charge a <u>copay</u> , <u>prescription</u> drugs, and <u>In-Network</u> <u>diagnostic</u> <u>tests</u> , <u>home 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. 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 <u>https://www.healthcare.gov/coverage/preventive-care-benefits/</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet deductibles for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	<u>In-Network</u> : \$3,000 Individual / \$9,000 Family <u>Out-of-Network</u> : \$6,000 Individual / \$18,000 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.
What is not included in the <u>out-of-pocket limit</u> ?	Deductibles, premiums, preauthorization penalties, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a <u>network provider</u> ?	Yes. See <u>www.bcbstx/com</u> or call 1-855-357-5228 for a list of <u>In-Network</u> providers.	This plan uses a <u>provider 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 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 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.

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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Information
	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 <u>\$10 copay</u> . In-Network.
If you visit a health care <u>provider's</u> office or clinic	<u>Specialist</u> visit	\$30 <u>copay</u> /visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
	Preventive care/screening/ immunization	No Charge; <u>deductible</u> does not apply	30% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your provider if the services needed are preventive. Then check what your <u>plan</u> will pay for. No Charge for child immunizations <u>Out-of-Network</u> through the 6 th birthday.
If you have a test	<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)	20% coinsurance	40% coinsurance	None

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

Common	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important
Medical Event		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Information
If you need drugs to treat your illness or condition More information about <u>prescription</u> <u>drug coverage</u> is available at: <u>www.mybenefits.org</u>	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 copay per 30-day supply
	Tier 2	Retail: \$25 <u>copay</u> / prescription Mail: \$50 <u>copay</u> / prescription; <u>deductible</u> does not apply	Total Cost of prescription	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
	Tier 3	Retail: \$40 <u>copay</u> / prescription Mail: \$80 <u>copay</u> / prescription; <u>deductible</u> does not apply	Total Cost of prescription	the Brand Name <u>Copayment</u> . <u>Specialty drug</u> prescriptions must be filled through Lumicera Specialty Pharmacy. One <u>copay</u> per 30-day supply.
	Specialty drugs	\$25 / \$40 <u>copay</u> / prescription; <u>deductible</u> does not apply	Total Cost of prescription	
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
surgery	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	20% <u>coinsurance</u> after \$150 <u>copay</u> /visit	20% <u>coinsurance</u> after \$150 <u>copay</u> /visit	Copay waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None



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

Common	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important
Medical Event		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Information
	<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)	20% coinsurance	40% coinsurance	All services must be preauthorized; \$250 penalty applies. <u>Out-of-Network</u> for failure to preauthorize.
otay	Physician/surgeon fees	20% <u>coinsurance</u>	40% coinsurance	None
If you need mental	Outpatient services	\$30 <u>copay</u> / office visit; <u>deductible</u> does not apply 20% <u>coinsurance</u> for other outpatient services	30% <u>coinsurance</u> office visit 40% <u>coinsurance</u> for other outpatient services	Limited to 30 visits per plan year. Substance abuse treatment limited to 3 series per lifetime. Certain services must be preauthorized; refer to benefit booklet for details.
health, behavioral health, or substance abuse services	Inpatient services	20% coinsurance	40% coinsurance	Limited to 30 days per plan year. Substance abuse treatment limited to 3 series per lifetime. All services must be preauthorized; \$250 penalty applies <u>Out-of-Network</u> for failure to preauthorize.
lf you are pregnant	Office visits	\$30 <u>copay</u> / initial visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	20% <u>coinsurance</u> applies after initial visit In- Network. <u>Cost sharing</u> 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.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	All services must be preauthorized; \$250 penalty applies <u>Out-of-Network</u> for failure to preauthorize.



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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Information
If you need help recovering or have other special health needs	Home health care	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.
	Rehabilitation services	\$30 <u>copay</u> / visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
	Habilitation services	\$30 <u>copay</u> / visit; <u>deductible</u> does not apply	30% coinsurance	None
	Skilled nursing care	No Charge; <u>deductible</u> does not apply	30% <u>coinsurance</u>	Limited to 25 days per plan year. All services must be preauthorized.
	Durable medical equipment	20% coinsurance	40% coinsurance	None
	Hospice services	No Charge; <u>deductible</u> does not apply	30% coinsurance	All services must be preauthorized.
If your child needs dental or eye care	Children's eye exam	No Charge; <u>deductible</u> does not apply	30% coinsurance	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 <u>plan</u> document for more infor	mation and a list of any other <u>excluded services</u> .)
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 <u>plan</u> document.)
Chiropractic care	 Non-emergency care when traveling 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, 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 Care.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 <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: Blue Cross Blue Shield of Texas at 1-855-357-5228 or visit <u>www.bcbstx.com</u>, or contact the U.S. Department of Labor's Employee Benefits Security Administrations at 1-866-444-EBSA (3272) or visit <u>www.dol.gov/ebsa/healthreform</u>. Contact the Texas Department of Insurance at 1-800-252-3439 or visit <u>www.texashealthoptions.com</u>.

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 <u>plan</u> doesn't meet the <u>Minimum Value Standards</u>, you may be eligible for a <u>premium tax credit</u> to help you pay for a <u>plan</u> through the <u>Marketplace</u>.

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, kwiijigo 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:

What isn't covered

\$60

\$3,060

Limits or exclusions

The total Joe would pay is

Limits or exclusions

The total Peg would pay is



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well- controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
The plan's overall deductible\$1,000Specialist copayment\$30Hospital (facility) coinsurance20%Other coinsurance20%		 The <u>plan's</u> overall <u>deductible</u> <u>Specialist</u> copayment Hospital (facility) coinsurance Other coinsurance 	\$1,000 \$30 20% 20%	 The <u>plan's</u> overall <u>deductible</u> <u>Specialist</u> copayment Hospital (facility) coinsurance Other coinsurance 	\$1,000 \$30 20% 20%
This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)		This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)		This EXAMPLE event includes services like: Emergency room care <i>(including medical supplies)</i> Diagnostic test <i>(x-ray)</i> Durable medical equipment <i>(crutches)</i> Rehabilitation services <i>(physical therapy)</i>	
Total Example Cost	\$12,800	Total Example Cost	\$7,400	Total Example Cost	\$1,900
In this example, Peg would pay: Cost Sharing		In this example, Joe would pay: Cost Sharing		In this example, Mia would pay: Cost Sharing	
Deductibles	\$1,000	Deductibles	\$1,000	Deductibles	\$1,000
Copayments	\$0	Copayments \$900		Copayments	\$400
Coinsurance \$2,000		Coinsurance	\$100	Coinsurance	\$30

What isn't covered		What isn't covered
sions \$60		Limits or exclusions
would pay is	\$2,060	The total Mia would pay is

The <u>plan</u> would be responsible for the other costs of these EXAMPLE covered services.

\$0

\$1,430

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.

ةيبر علا	إناك كيدا وأ بدا صخشد هدعاسة تمانسا، كيداف ق لوصحا على قدعاسما تامولعمالو تميرورضا اكتغابان مود تميا تكلفة. ثدحتلا لى إمجرتم يروف، لصتا على مقر تمدد علامعا روكذما على ريظ مقاطب كتيوضع. ن إفرانكة عضه اؤ، وأ تنك
Arabic	لا لنامة تقاطب لصتاف على 6984-11-855.
繁體中文	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
Chinese	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.
�ઙ્ર ૨ાતી	જો તમને અથવા તમે મદદ કર¢ રહ્યા હોય એવી કોઈ બી� વ્યાક્ત્તને એસ.બી.એમ. �ુભાિષયા સાથે વાત કરવા માઢ¢, તમારા સભ્યપદના કાડર,ની પાછળ
Gujarati	આપેલ ગ્રાહક સેવા નલ ૨ પર કૉલ કરો. જો આપ સભ્યપદ ના ધરાવતા હોવ, અથવા આપની પાસે કાડર નથી તો 855-710-6984 નલ ૨ પર કૉલ કરો.
≬हंद≬ Hindi	य�द आपके, या आप िजसक≬ सहायता कर रहे ल उसके, प्रश्न ल, तो आपको अपनी भाषा म �नःशुल्क सहायता और जानकार≬ प्राप््त करने का अ�धकार है। �कसी अनुवादक से बात करने के �लए, अपने सदस्य काडर के पीछे �दए गए ग्राहक सेवा नंबर पर कॉल कर�। य�द आप सदस्य नह¢ं ल, या आपके पास काडर् नह¢ं है, तो 855-710-6984 पर कॉल कर�।
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	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
Korean	전화하십시오. 회원이 아니시거나 카드가 없으시면 855-710-6984 으로 전화주십시오.
ພາສາລາວ Laotian	ຖ້າທ່ານ ືຫຼຸຄຸ້ນິທທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼອືມໍຄາຖາມ,ທ່່ານີມິສດໍຂເົອາການຊ່ວຍເຫຼອ ແລະໍຂມູນເປັນນພາສາຂອງທ່ານໄດ້ໂດຍໍບິມຄ່າໃຊ້ຈ່າຍ. ເພື່ອລົມກັບນາຍແປພາສາ,ໃຫ້ໂທຫາເວີບຜ່າຍໍບິລ ການລູກຄ້າວິທີ່ນຢູ່ດ້ານຫຼັງທັດສະມາິຊກຂອງທ່ານ. ຖ້າທ່ານໍບແມ່ນສະມາິຊກ, ືຫຼໍບ _ິ ມທັດ, ໃຫ້ ໂທຫາເວັບ 855-710-6984.
Diné Navajo	T'11 ni, 47 doodago [a'da b7k1 an1n7lwo'7g77, na'7d7[kidgo, ts'7d1 bee n1 ah00ti'i' t'11 n77k'e n7k1 a'doolwo[. Ata' halne'7 bich'8' hadeesdzih n7n7zingo 47 kwe'4 da'7n7ishgi 1k1 an7daalwo'7g77 bich'8' hod77lnih, bee n44h0zinii bine'd66' bik11'. Koj7 atah naaltsoos n1 had7t'44g00 47 doodago bee n44h0zin7g77 1dingo koj8' hod77lnih 855-710-6984.
ىسر ^{ياۋ}	رگا امش، به شما که کسی یا وا می کمک دیند، ملاؤسه متشاد دیشاب، ق دنیا ار دیر اد به که نابز دوخ، به روط ناگیار کمک و تاعلاطا تفایرد دییامذ. تهج و گتفاً یک با مجرتم ی هافش، با تامدخ یرتشم به هر امش یا که رد تشپ تر اک تیوضت شما
Persian	جرد هدش تسما س امد دیریگر. رگا وضت دیتسین، یا تر اک تیوضت دیر ادن، با هر امشه 6984-510-855 س امد لییامذ.
Русский	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-
Russian	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	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-
Tagalog	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	۔ ریرک رگ پآ وک کسی یا ےسیا در فوک سج کی پآ ددم ےہررک ریپ، کوک لاوسا شریپرد ہے وت، پآ وک کنپا ن ابز ریم تغم ددم روا ت امولعم لصاح نزک کا قح ہے۔ مجر تم سے ت ابے نرک کے ےیل، رمٹسک سور سر رہذ رپ ل اک ریرک وج پآ کے
Urdu	ڈراک کی تشپ رپ جرد ہے۔ رگا پآ رہم ریپذ رپ اپ ڈراک ریپہ ہے وت، 45 - 105 رپ ل اک
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: <u>CivilRightsCoordinator@hcsc.net</u>

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