Coverage for: Individual/Family | \underline{Plan} Type: PPO

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 by calling 1-855-258-3489 or at www.bcbsmt.com. 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 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? | \$500 Individual / \$1,500 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 deductible? | Yes. <u>Prescription drugs</u> , <u>hospice</u> , well-child, and preventive health care 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>www.healthcare.gov/coverage/preventive-care-benefits/</u> . |
| Are there other <u>deductibles</u> for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ? | \$2,000 Individual / \$6,000 Family Prescription drug limit: \$1,650 Individual / \$3,300 Family | 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 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> . |
| Will you pay less if you use a <u>network provider</u> ? | Yes. See www.bcbsmt.com or call 1-855-258-3489 for a list of participating providers . | 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 <u>referral</u> to see a <u>specialist</u> ? | No. | You can see the specialist you choose without a referral. |



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

| | | What You | u Will Pay | |
|---|--|--|---|---|
| Common Medical Event | Services You May Need | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
| | Primary care visit to treat an injury or illness | 20% coinsurance | 30% coinsurance | None |
| | Specialist visit | 20% coinsurance | 30% coinsurance | None |
| If you visit a health care provider's office or clinic | Preventive care/screening/immunization | No Charge; deductible does not apply | No Charge; deductible does not apply | Maximum of one electric breast pump per year. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. |
| If you have a toot | Diagnostic test (x-ray, blood work) | 20% coinsurance | 30% coinsurance | <u>Preauthorization</u> may be required; see your member guide* for details. |
| If you have a test | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 30% coinsurance | <u>Preauthorization</u> may be required; see your member guide* for details. |
| | Generic drugs | Value Retail: \$15 <u>copayment</u> Mail: \$30 <u>copayment</u> ESN: \$45 <u>copayment</u> ; <u>deductible</u> does not apply | Retail: \$15 <u>copayment;</u> <u>deductible</u> does not apply | Prescription drug out-of-pocket limit: \$1,650 Individual / \$3,300 Family |
| If you need drugs to treat your illness or condition More information about prescription | Preferred brand drugs | Value Retail: \$40 <u>copayment</u> Mail: \$80 <u>copayment</u> ESN: \$120 <u>copayment</u> ; <u>deductible</u> does not apply | Retail: \$40 <u>copayment;</u> <u>deductible</u> does not apply | Limited to a 30-day supply at retail (or a 90-day supply at an extended supply network of retail pharmacies - ESN). Up to a 90-day supply at an approved mail order pharmacy. Specialty drugs limited to a 30-day supply. |
| drug coverage is available at www.bcbsmt.com/rx. | Non-preferred brand drugs | Value Retail: 50% coinsurance Mail: 50% coinsurance ESN: 50% coinsurance; deductible does not apply | Retail: 50% <u>coinsurance;</u> <u>deductible</u> does not apply | Payment of the difference between the cost of a brand name drug and a generic may also be required if a generic drug is available. The difference will not apply to any deductible or out-of-pocket amounts. |
| | Specialty drugs | \$150/prescription; deductible does not apply | \$150/prescription; deductible does not apply | |

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.bcbsmt.com</u>.

| Common Medical Event | Services You May Need | What You <u>Network Provider</u> (You will pay the least) | u Will Pay Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|--|--|---|---|--|
| If you have | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 30% coinsurance | Preauthorization may be required; see your member guide* for details. |
| outpatient surgery | Physician/surgeon fees | 20% coinsurance | 30% coinsurance | For Outpatient Infusion Therapy see your member guide* for details. |
| | Emergency room care | 20% coinsurance | 20% coinsurance | None |
| If you need immediate medical attention | Emergency medical transportation | 20% coinsurance | 20% coinsurance | Preauthorization may be required for non-emergency transportation; see your member guide* for details. |
| | Urgent care | 20% coinsurance | 30% coinsurance | None |
| If you have a | Facility fee (e.g., hospital room) | 20% coinsurance | 30% coinsurance | Preauthorization required. |
| hospital stay | Physician/surgeon fees | 20% coinsurance | 30% coinsurance | None |
| If you need mental | Outpatient services | 20% coinsurance | 20% coinsurance | Preauthorization may be required; see your member guide* for details. |
| health, behavioral health, or substance abuse services | Inpatient services | 20% <u>coinsurance</u> | 20% coinsurance | Preauthorization required. Residential treatment facilities will be covered if medical necessity criteria are met. |
| | Office visits | 20% coinsurance | 30% coinsurance | Cost sharing does not apply to certain preventive services. Depending on the type |
| If you are pregnant | Childbirth/delivery professional services | 20% coinsurance | 30% coinsurance | of services, a <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include |
| you alo prognant | Childbirth/delivery facility services | 20% <u>coinsurance</u> | 30% coinsurance | tests and services described elsewhere in the SBC (i.e. ultrasound). Preauthorization may be required. |

^{*} For more information about limitations and exceptions, see the $\underline{\text{plan}}$ or policy document at $\underline{\text{www.bcbsmt.com}}$.

| Common | What You Will Pay | | Limitations, Exceptions, & Other | |
|---|----------------------------|---|---|--|
| Medical Event | Services You May Need | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Important Information |
| | Home health care | 20% coinsurance | 20% coinsurance | Preauthorization may be required. 100 visit maximum per benefit period. |
| | Rehabilitation services | 20% coinsurance | 30% coinsurance | Preauthorization may be required. |
| If you need help | Habilitation services | 20% coinsurance | 30% coinsurance | Preauthorization may be required. |
| recovering or have other special health needs | Skilled nursing care | 20% coinsurance | 20% coinsurance | Preauthorization may be required. 90 days maximum per benefit period. |
| | Durable medical equipment | 20% coinsurance | 20% coinsurance | Preauthorization may be required. |
| | Hospice services | No Charge; deductible does not apply | No Charge; deductible does not apply | Preauthorization may be required. |
| | Children's eye exam | Not Covered | Not Covered | None |
| If your child needs | Children's glasses | Not Covered | Not Covered | None |
| dental or eye care | Children's dental check-up | 20% coinsurance after \$25 deductible. | 20% coinsurance after \$25 deductible. | Limited to two exams per calendar year. \$3,000 maximum per benefit period. |

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.)

- Bariatric surgery
- Cosmetic surgery (except for the correction of congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases)
- Hearing aids (except for dependent children under age 19, per medical policy)
- Infertility treatment
- Long-term care
- Private-duty nursing

- Routine eye care (Adult)
- Routine foot care (except for individuals with comorbidities, such as diabetes)
- Weight loss programs

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

Acupuncture

Chiropractic care

Naturopath

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.bcbsmt.com</u>.

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 <u>plan</u> at 1-855-258-3489 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 Montana at 1-855-258-3489 the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform, or the Montana Commissioner of Securities and Insurance at 1-406-444-2040 or 1-800-332-6148 or visit www.csi.mt.gov. Contact the Montana Consumer Assistance Program at 1-800-332-6148 or visit www.csi.mt.gov.

Does this <u>plan</u> provide <u>Minimum Essential Coverage</u>? 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 1-855-258-3489.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-258-3489.

Chinese (中文): 如果需要中文的帮助,请拨打这个号码1-855-258-3489.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-258-3489.

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 <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 plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of <u>in-network</u> pre-natal care and a hospital delivery)

| ■ The <u>plan's</u> overall <u>deductible</u> | \$500 |
|---|-------|
| ■ Specialist coinsurance | 20% |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 20% |

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 |
|---------------------------|----------|
| | |

In this example, Peg would pay:

| Cost sharing | |
|----------------------------|---------|
| <u>Deductibles</u> | \$500 |
| Copayments | \$0 |
| Coinsurance | \$1,500 |
| What isn't covered | |
| Limits or exclusions | |
| The total Peg would pay is | \$2,060 |

Managing Joe's type 2 Diabetes

(a year of routine <u>in-network</u> care of a well-controlled condition)

| ■ The plan's overall deductible | \$500 |
|---------------------------------|-------|
| Specialist coinsurance | 20% |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (*including disease education*)
Diagnostic tests (*blood work*)

Prescription drugs

<u>Durable medical equipment</u> (glucose meter)

| Total Example Cost | \$5,600 |
|---------------------------|---------|
| | |

In this example, Joe would pay:

| <u>Cost sharing</u> | |
|----------------------------|---------|
| <u>Deductibles</u> | \$500 |
| Copayments | \$700 |
| Coinsurance | \$300 |
| What isn't covered | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$1,520 |

Mia's Simple Fracture

(<u>in-network</u> emergency room visit and follow up care)

| ■ The plan's overall deductible | \$500 |
|-----------------------------------|-------|
| ■ Specialist coinsurance | 20% |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 20% |

This EXAMPLE event includes services like:

<u>Emergency room care</u> (including medical supplies)

Diagnostic test (x-ray)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

| Total Example Cost | \$2,800 |
|--------------------|---------|
|--------------------|---------|

In this example, Mia would pay:

| Cost sharing | | |
|----------------------------|---------|--|
| <u>Deductibles</u> | \$500 | |
| <u>Copayments</u> | \$10 | |
| Coinsurance | \$500 | |
| What isn't covered | | |
| Limits or exclusions | \$0 | |
| The total Mia would pay is | \$1,010 | |



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 تساعده أسئلة، فلديك 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 858-710-858. |
|--------------------------|--|
| ଧୃକ୍ଷାଧ୍ୟ Burmese | သင် သို့မဟုတ် သင်ကူညီပေးနေသူတဦးမှ မေးမြန်းလိုသည့် မေးခွန်းများရှိပါက သင့် ဘာသာစကားဖြင့် အကူအညီနှင့် အချက်အလက်များကို အခမဲ့ဖြင့်ရယူနိုင်သည့်အခွင့်အရေးရှိပါသ ည်။ ဘာသာစကား ပြန်ဆိုသူနှင့် စကားပြောရန် သင့် အဖွဲ့ ဂင်ကဒ်၏ နောက်ကျောဇက်ပေါ် ရှိ သုံးစွဲသူ ဂန်ဆောင်မှု ဖုန်းနံပါတ်သို့ ခေါ်ဆိုပါ။ အကယ်၍ သင်သည် အဖွဲ့ ဂင်တစ်ဦး မဟုတ်ခဲ့ပါက သို့မဟုတ် ကဒ် မရှိပါက 855- 710-6984 သို့ ခေါ်ဆိုပါ။ |
| GWY Cherokee | haz, D6 ygt ө amspmey, corrwos, ha cap omy rgpmsha d6 rgz4a cu gchama ewov d4v°v°. omyz dapady colszpat, ወрabwrb omyot chgmy dolwspmy omy ppt gvp sar dthrma sawht a4ma. apo hbro ay, d6 dthrma hcoo ay, ombwrs daph 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. |
| Hmoob Hmong | Yog koj, los yog tej tus neeg uas koj pab ntawd muaj lus nug txog, koj muaj cai hais kom lawv pab muab cov ntaub ntawv sau ua koj hom lus pub dawb rau koj. Xav tham nrog ib tug kws txhais lus, hu rau tus nab npawb xovtooj pab cuam neeg qhua uas nyob sab tom qab ntawm koj daim npav tswv cuab. Yog koj tsis yog ib tug neeg tswv cuab, los yog koj tsis muaj npav, hu rau 855-710-6984. |
| 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 아니시거나 카드가 없으시면 855-710-6984 으로 전화주십시오. |
| ພາສາລາວ Laotian | ຖ້າທ່ານ ຫຼື ຄົນທີທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອມີຄຳຖາມ, ທ່ານມີສິດຂໍເອົາການຊ່ວຍເຫຼືອ ແລະ ຂໍມູນເປັນນພາສາຂອງທ່ານໄດ້ໂດຍບໍມີຄ່າ ໃຊ້ຈ່າຍ. ເພື່ອລົມກັບນາຍແປພາສາ, ໃຫ້ໂທຫາເບີຜ່າຍບໍລິການລູກຄ້າທີ່ມີຢູ່ດ້ານຫຼັງບັດສະມາຊິກຂອງທ່ານ. ຖ້າທ່ານບໍ່ແມ່ນສະມາຊິກ, ຫຼື ບໍ່ມີບັດ, ໃຫ້ໂທຫາເບີ 855-710-6984. |
| Diné Navajo | T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'idílkidgo, ts'idá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł. Ata' halne'í bich'į' hadeesdzih nínízingo éí kwe'é da'íníishgi áká anídaalwo'ígíí bich'į' hodíílnih, bee nééhózinii bine'déé' bikáá'. Kojí atah naaltsoos ná hadít'éégóó éí doodago bee nééhózinígíí ádingo kojį' hodíílnih 855-710-6984. |
| فارسی Persian | اگر شما، یا کسی که شما به او کمک می کنید، سؤالی 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 یشت کارت عضویت ندارید، با شماره 898-710-858 تماس حاصل نمایید. در ج شده است تماس بگیرید. اگر عضو نیستید، یا کارت عضویت ندارید، با شماره 898-710-858 تماس حاصل نمایید. |
| 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. |
| ไทย Thai | หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีข้อสงสัยใด ๆ คุณมีสิทธิที่จะได้รับความช่วยเหลือ และข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่ามโดยติดต่อฝ่ายบริการลูกค้าที่หมายเลขตามที่ระบุด้านหลังบัตรสมาชิก หากไม่ใช่สมาชิกหรือไม่มีบัตร กรุณาติดต่อที่หมายเลข 855-710-6984 |
| اردو Urdu | گر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کر رہے ہیں، کوئی سوال در پیش 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، 1896-710-855 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 Phone: 855-664-7270 (voicemail)

300 E. Randolph St. TTY/TDD: 855-661-6965 35th Floor Fax: 855-661-6960

Chicago, Illinois 60601 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 Complaint Forms: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf Complaint Forms: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf Complaint Forms: https://www.hhs.gov/ocr/office/file/index.html