



 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/member/policy-forms/2017](http://www.bcbstx.com/member/policy-forms/2017) or by calling 1-877-299-2377. 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/Downloads/UG-Glossary-508-MM.pdf> or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	Participating \$2,850 Individual/\$8,550 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 deductible?</b>	Doesn't apply to certain services that charge a copay, <u>Preventive Care</u> , and <u>Prescription Drugs</u> . Copays don't count toward the <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 preventive services without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	Yes. For Participating \$6,850 Individual/\$13,700 Family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.
<b>What is not included in the out-of-pocket limit?</b>	<u>Premiums</u> , balance-billed 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 limit</u> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.bcbstx.com">www.bcbstx.com</a> for a list of <u>Participating 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</u> network. 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.
<b>Do you need a referral to see a specialist?</b>	Yes. All <u>Specialist</u> visits require a <u>written</u> PCP <u>Referral</u> unless it's for an OB/GYN or for emergency care.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a referral before you see the <u>specialist</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
		Participating Provider (You will pay the least)	Non-Participating 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	\$40 <u>copay</u> /visit	Not Covered	none  You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your <u>plan</u> will pay for.
	<u>Specialist</u> visit	\$65 <u>copay</u> /visit	Not Covered	
	<u>Preventive care/screening/immunization</u>	No Charge	Not Covered	
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	30% <u>coinsurance</u>	Not Covered	none  <u>Deductible</u> and <u>coinsurance</u> do not apply; other focus procedures take the office visit copay.
	Imaging (CT/PET scans, MRIs)	\$250 <u>copay</u> /test	Not Covered	
<b>If you need drugs to treat your illness or condition</b>  More information about <b>prescription drug coverage</b> is available at <a href="https://www.myprime.com/content/dam/prime/memberportal/forms/AuthorForms/IVL/2017/2017_TX_5T_EX.pdf">https://www.myprime.com/content/dam/prime/memberportal/forms/AuthorForms/IVL/2017/2017_TX_5T_EX.pdf</a>	Preferred generic drugs	Retail - No Charge/\$5 copay Mail - No Charge	Not Covered	Lower copay applies at preferred Participating pharmacies. One copay per 30-day supply - up to a 90-day supply for generic and brand drugs, up to a 30-day supply for <u>Specialty Drugs</u> . 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. Certain women's preventive services will be covered with no cost to the member.
	Non-preferred generic drugs	Retail - \$10/\$15 copay Mail - \$30 copay	Not Covered	
	Preferred brand drugs	Retail - \$50/\$60 copay Mail - \$150 copay	Not Covered	
	Non-preferred brand drugs	Retail - \$100/\$110 copay Mail - \$300 copay	Not Covered	
	Specialty drugs	\$150 copay	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$200 <u>copay</u> /procedure plus 30% <u>coinsurance</u>	Not Covered	Copay is charged in addition to the overall <u>Deductible</u> . Elective abortion is not covered except in limited circumstances.  Termination of pregnancy is not covered except in limited circumstances.
	Physician/surgeon fees	30% <u>coinsurance</u>	Not Covered	

\* For more information about limitations and exceptions, see the plan or policy document at [www.bcbstx.com/member/policy-forms/2017](http://www.bcbstx.com/member/policy-forms/2017).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
<b>If you need immediate medical attention</b>	Emergency room care	\$500 <u>copay</u> /visit plus 30% <u>coinsurance</u>	\$500 <u>copay</u> /visit plus 30% <u>coinsurance</u>	Copay is charged in addition to the overall <u>Deductible</u> and is waived if admitted.
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	none
	<u>Urgent care</u>	\$75 <u>copay</u> /visit	Not Covered	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$250 <u>copay</u> /admit plus 30% <u>coinsurance</u>	Not Covered	Copay is charged in addition to the overall <u>Deductible</u> .
	Physician/surgeon fees	30% <u>coinsurance</u>	Not Covered	none
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$40 <u>copay</u> for office visits or 30% <u>coinsurance</u> for other outpatient services	Not Covered	Inpatient copay is charged in addition to the overall <u>Deductible</u> .
	Inpatient services	\$250 <u>copay</u> /admit plus 30% <u>coinsurance</u>	Not Covered	
<b>If you are pregnant</b>	Office visits	\$40 <u>copay</u> /Primary care/\$60 <u>copay</u> /Specialist for initial visit	Not Covered	Copay applies to first prenatal visit (per pregnancy) <u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, <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	30% <u>coinsurance</u>	Not Covered	Copay is charged in addition to the overall <u>Deductible</u> .
	Childbirth/delivery facility services	\$250 <u>copay</u> /admit plus 30% <u>coinsurance</u>	Not Covered	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	30% <u>coinsurance</u>	Not Covered	60 visit maximum per benefit period.
	<u>Rehabilitation services</u>	30% <u>coinsurance</u>	Not Covered	35 visit maximum per benefit period, including chiropractic.
	<u>Habilitation services</u>	30% <u>coinsurance</u>	Not Covered	
	<u>Skilled nursing care</u>	30% <u>coinsurance</u>	Not Covered	25 day maximum per benefit period.
	<u>Durable medical equipment</u>	30% <u>coinsurance</u>	Not Covered	none
	<u>Hospice services</u>	30% <u>coinsurance</u>	Not Covered	

\* For more information about limitations and exceptions, see the plan or policy document at [www.bcbstx.com/member/policy-forms/2017](http://www.bcbstx.com/member/policy-forms/2017).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
<b>If your child needs dental or eye care</b>	Children's eye exam	No Charge	No Charge	One visit per year. Reimbursed up to \$30 Non-Participating. See benefit booklet for network details.
	Children's glasses	No Charge	No Charge	One pair of glasses per year. Up to \$150 Participating. Reimbursed up to \$45 frames/\$25 single vision lenses Non-Participating. See benefit booklet for network details.
	Children's dental check-up	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Two visits per year. See benefit booklet for network details

#### 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.)

- Abortions (except where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a physician, places the woman in danger of death unless an abortion is performed)
- Acupuncture
- Bariatric surgery
- Dental Care(Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (Only covered for extended care expenses)
- Routine eye care(Adult)
- Weight loss programs

##### Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Cosmetic surgery (Only covered for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases. when medically necessary.)
- Hearing aids (Limited to one for each ear every three years)
- Infertility treatment (Diagnosis covered but treatment and Invitro not covered)
- Routine foot care (Only covered in connection with diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency)

**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 1-877-299-2377, 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.

\* For more information about limitations and exceptions, see the plan or policy document at [www.bcbstx.com/member/policy-forms/2017](http://www.bcbstx.com/member/policy-forms/2017).

**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 1-877-299-2377 or visit [www.bcbstx.com](http://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](http://www.dol.gov/ebsa/healthreform).

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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): Spanish (Español): Para obtener asistencia en Español, llame al 1-877-299-2377.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-299-2377.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-299-2377.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiiijigo holne' 1-877-299-2377.

—————*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)

■ <b>The plan's overall deductible</b>	\$2,850
■ <b>Specialist copayment</b>	\$65
■ <b>Hospital (facility) both</b>	\$250 + 30%
■ <b>Other coinsurance</b>	30%

**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>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$2,850
Copayments	\$500
Coinsurance	\$2,700
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$6,110</b>

### Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)

■ <b>The plan's overall deductible</b>	\$2,850
■ <b>Specialist copayment</b>	\$65
■ <b>Hospital (facility) both</b>	\$250 + 30%
■ <b>Other coinsurance</b>	30%

**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:**

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$600
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$760</b>

### Mia's Simple Fracture (in-network emergency room visit and follow up care)

■ <b>The plan's overall deductible</b>	\$2,850
■ <b>Specialist copayment</b>	\$65
■ <b>Hospital (facility) both</b>	\$250 + 30%
■ <b>Other coinsurance</b>	30%

**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>\$2,000</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$200
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,400</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.

العربية Arabic	إن كان لديك أو لدى شخص تساعدك أسئلة، فإليك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث إلى مترجم فوري، اتصل على رقم خدمة العملاء المذكور على ظهر بطاقة عضويتك. فإن لم تكن عضواً، 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、情報を入力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 ທ່ານມີສິດຂໍອີກການຊ່ວຍເຫຼືອ ແລະ ຂໍມູນບັນນາທາສາຂອງທ່ານໄດ້ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ ເພື່ອນັກບາຍເບຣັກໄວລາສາ. ໃຫ້ໂທຫາເບີຟາກບໍລິການລູກຄ້າທີ່ມີຢູ່ດ້ານຫຼັງບັດສະມາຊິກຂອງທ່ານ. ຖ້າທ່ານບໍ່ເປັນສະມາຊິກ ຫຼື ບໍ່ມີບັດ, ໃຫ້ໂທຫາເບີ 855-710-6984.
Diné Navajo	T'áá ni, éí doodago ła'da biká anánilwo'ígíí, na'ídiłkídogo, ts'ídá bee ná ahóótí'i' t'áá níik'e níká a'doolwoł. Ata' halne'í bich'í' hadeesdzih nínízingo éí kwe'é da'íníishgí áká anídaalwo'ígíí bich'í' hodíłnih, bee nééhózinii bine'déé' bikáá'. Kojí atah naaltsoos ná hadít'éé'góó éí doodago bee nééhózinígíí ádingo kojí' hodíłnih 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سوالی 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	گر 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, 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  
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>