The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-855-322-4953 or visit www.MUSTbenefits.org. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cms.gov/cciio/resources/forms-reports-and-other-resources/downloads/ug-glossary-508-mm.pdf or call 1-855-322-4953 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tier 1 - Blue Options: $3,500 Individual / $7,000 Family Tier 2 - Blue Preferred: $5,000 Individual / $10,000 Family Tier 3 - Out-of-Network: $11,000 Individual / $22,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Prescription drugs, services that charge a copay, chiropractic care, diabetic education, acupuncture, travel benefit, breast pumps, mammograms, and preventive health & well-child are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Tier 1 - Blue Options: $5,000 Individual / $10,000 Family Tier 2 - Blue Preferred: $5,500 Individual / $11,000 Family Tier 3 - Out-of-Network: $12,300 Individual / $24,600 Family Prescription drug limit: $1,650 person / $3,300 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, 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 network provider?	Yes. See www.bcbsmt.com or call1-855-322-4953 for a list of participating providers.	You pay the least if you use a provider in Blue Options. You pay more if you use a Blue Preferred provider. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	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.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Provider (You will pay the least)	Tier 2 Provider	Tier 3 Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit; deductible does not apply	40% coinsurance	50% coinsurance	Virtual visits available through MDLIVE: $25 copay; deductible does not apply.
	Specialist visit	$50 copay/visit; deductible does not apply	40% coinsurance	50% coinsurance	None
	Preventive care/screening/ immunization	No Charge; deductible does not apply	No Charge; deductible does not apply	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Coverage for a pap test limited to 1 per plan year. Coverage for colonoscopy limited to 1 every 10 years beginning at age 50.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	40% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	40% coinsurance	50% coinsurance	None

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Provider (You will pay the least)	Tier 2 Provider	Tier 3 Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.MUSTbenefits.org	Preferred generic drugs	Retail: $10 copay Mail: $20 copay; deductible does not apply	Retail: $10 copay Mail: $20 copay; deductible does not apply	Retail: $10 copay; deductible does not apply	Prescription drug out-of-pocket limit: $1,650 person / $3,300 family Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription at a plan approved mail order pharmacy); 90-day supply (retail extended supply network pharmacy). Specialty drugs covered up to a 30-day supply. Extended Supply Network copayments are two times retail copayments.
	Non-preferred generic drugs	Retail: $30 copay Mail: $60 copay; deductible does not apply	Retail: $30 copay Mail: $60 copay; deductible does not apply	Retail: $30 copay; deductible does not apply	
	Preferred brand drugs	Retail: $50 copay Mail: $100 copay; deductible does not apply	Retail: $50 copay Mail: $100 copay; deductible does not apply	Retail: $50 copay; deductible does not apply	
	Non-preferred brand drugs	Retail: $150 copay Mail: $300 copay; deductible does not apply	Retail: $150 copay Mail: $300 copay; deductible does not apply	Retail: $150 copay; deductible does not apply	
	Preferred specialty drugs	Retail: $150 copay; deductible does not apply	Retail: $150 copay; deductible does not apply	Retail: $150 copay; deductible does not apply	
	Non-preferred specialty drugs	Retail: $300 copay; deductible does not apply	Retail: $300 copay; deductible does not apply	Retail: $300 copay; deductible does not apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance	50% coinsurance	Preauthorization required.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	50% coinsurance	None

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Provider (You will pay the least)	Tier 2 Provider	Tier 3 Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$200 copay/visit; deductible does not apply	$200 copay/visit; deductible does not apply	$200 copay/visit; deductible does not apply	The plan pays the first $500 of eligible expenses for accident injuries; deductible and coinsurance waived. Copay waived if admitted. Professional services in the ER are 10% coinsurance.
	Emergency medical transportation	10% coinsurance	10% coinsurance	10% coinsurance	None
	Urgent care	$50 copay/visit; deductible does not apply	40% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	40% coinsurance	50% coinsurance	Preauthorization required.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/visit; deductible does not apply	40% coinsurance	50% coinsurance	First 3 visits per plan year not subject to deductible and coinsurance. Subsequent visits $25 copay per visit.
	Inpatient services	10% coinsurance	40% coinsurance	50% coinsurance	Preauthorization required.
If you are pregnant	Office visits	$25 copay/visit; deductible does not apply	40% coinsurance	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	40% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	40% coinsurance	50% coinsurance	Preauthorization required.

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Provider (You will pay the least)	Tier 2 Provider	Tier 3 Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	40% coinsurance	50% coinsurance	180 day combined maximum for home health care and hospice. Preauthorization required.
	Rehabilitation services	$25 copay/visit; deductible does not apply	40% coinsurance	50% coinsurance	Outpatient physical, occupational, speech, and cardiac therapies have a combined 50 visit maximum per benefit period. Inpatient physical, occupational, speech, and cardiac therapies have a combined 60 day maximum per benefit period. Preauthorization required for inpatient therapies.
	Habilitation services	10% coinsurance	40% coinsurance	50% coinsurance	No Applied Behavior Analysis (ABA) benefits for Autism Spectrum Disorder available for members 19 years of age or older.
	Skilled nursing care	10% coinsurance	40% coinsurance	50% coinsurance	60 days maximum per benefit period. Preauthorization required.
	Durable medical equipment	10% coinsurance	40% coinsurance	50% coinsurance	None
	Hospice services	10% coinsurance	40% coinsurance	50% coinsurance	180 day combined maximum for home health care and hospice. Preauthorization required.
If your child needs dental or eye care	Children's eye exam	No Charge; deductible does not apply	No Charge; deductible does not apply	No Charge; deductible does not apply	Limited to 1 exam per benefit plan year.
	Children's glasses	Not Covered	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	Not Covered	None

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

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 • Dental care (Adult)	• Hearing aids • Infertility treatment • Long term care	• Non-emergency care when traveling outside the U.S. • Private-duty nursing • Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Chiropractic care	• Most coverage provided outside the United States. See www.bcbsmt.com. • Routine eye care (Adult)	• Weight loss programs

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 1-855-322-4953, 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 1-855-322-4953 or visit www.bcbsmt.com, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Montana Consumer Assistance Program at 1-800-332-6148 or www.csi.mt.gov.

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): Para obtener asistencia en Español, llame al 1-855-322-4953.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-322-4953.
Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 1-855-322-4953.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-322-4953.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$3,500**
- **Specialist copayments** **$50**
- **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)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,500
Copayments	$100
Coinsurance	$900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,560**

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

- **The plan's overall deductible** **$3,500**
- **Specialist copayments** **$50**
- **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)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$3,160**

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

- **The plan's overall deductible** **$3,500**
- **Specialist copayments** **$50**
- **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)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,100
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,600**

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

BlueCross BlueShield of Montana

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 855-710-6984.
မြန်မာ Burmese	သင် သို့မဟုတ် သင်ကူညီပေးနေသူတဦးမှ မေးမြန်းလိုသည့် မေးခွန်းများရှိပါက သင့် ဘာသာစကားဖြင့် အကူအညီနှင့် အချက်အလက်များကို အခမဲ့ဖြင့်ရယူနိုင်သည့်အခွင့်အရေးရှိပါသည်။ ဘာသာစကား ပြန်ဆိုသူနှင့် စကားပြောရန် သင့် အဖွဲ့ဝင်ကတ်၏ နောက်ကျောဖက်ပေါ်ရှိ သုံးစွဲသူ ဝန်ဆောင်မှု ဖုန်းနံပါတ်သို့ ခေါ်ဆိုပါ။ အကယ်၍ သင်သည် အဖွဲ့ဝင်တစ်ဦး မဟုတ်ပါက သို့မဟုတ် ကတ် မရှိပါက 855-710-6984 သို့ ခေါ်ဆိုပါ။
ᏣᎳᎩ Cherokee	ᏂᎯᏃ, ᎠᏎ ᏰᎦᎢ Ꮎ ᎠᏍᏕᎸᏗᏱ, ᏯᏛᏛᏅᏍᏛ, ᏂᎯ ᏣᏥ ᎾᏍᎩ ᎱᏢᏍᏕᎵᏗ ᎠᏎ ᎱᏃᏯᏗ ᏣᏪ ᏣᏛᏂᎯᏍᏗ ᎧᏬᏂᎯ ᎠᏰᏉᏉ. ᎾᏍᎩᏃ ᎠᏁᏢᏗᏍᎩ ᏣᏍᏆᏠᏱᏢᏗᎢ, ᏫᏂᎯᏏᏔᏅᏏ ᎾᏍᎩᎾᎢ ᎤᏂᎦᏍᎩ ᎠᎾᏓᏍᏕᎵᏍᎩ ᎾᏍᎩ ᏈᏗ ᎣᏓᏢ ᎣᏍᏛ ᎠᏂᏏᎦᏍᎩ ᏚᏯᏴᎢ ᏗᏜᏍᏗ. ᏁᏢᎾ ᏂᏢᎡᎾ ᏥᎩ, ᎠᏎ ᎠᏂᏏᎦᏍᎩ ᏂᎪᏒᎾ ᏥᎩ, ᏫᏍᏓᏩᏛᏎ ᎠᏓᏂ 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 ຄົນທີ່ທ່ານກໍາລັງໃຫ້ການຊ່ວຍເຫຼືອມີຄໍາຖາມ, ທ່ານມີສິດຂໍຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໄດ້ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອລົມກັບນາຍແປພາສາ, ໃຫ້ໂທຫາເບີຝ່າຍບໍລິການລູກຄ້າທີ່ມີຢູ່ດ້ານຫຼັງບັດສະມາຊິກຂອງທ່ານ. ຖ້າທ່ານບໍ່ແມ່ນສະມາຊິກ, ຫຼື ບໍ່ມີບັດ, ໃຫ້ໂທຫາເບີ 855-710-6984.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídílkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł. Ata' halne'í bich'į' hadeesdzih nínízingo éí kwe'é da'íníishgi ákó anídaalwo'ígíí bich'į' hodíílnih, bee néého̜zinii bine'déé' bikáá'. Kojí atah naaltsoos ná hadít'éégóó éí doodago bee néého̜zinígíí ádingo koji' 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 پشت کارت عضویت شما درج شده است تماس بگیرید. اگر عضو نیستید، یا کارت عضویت ندارید، با شماره 855-710-6984 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	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے 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	Phone:	855-664-7270 (voicemail)
300 E. Randolph St.	TTY/TDD:	855-661-6965
35th Floor	Fax:	855-661-6960
Chicago, Illinois 60601	Email:	CivilRightsCoordinator@hcsc.net

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

U.S. Dept. of Health & Human Services	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