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/ccio/resources/forms-reports-and-other-resources/downloads/ug-glossary-508-mm.pdf or call 1-855-756-4448 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$2,000 person / $4,000 family</td>
<td>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.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Prescription drugs, services that charge a copay, initial accident care, chiropractic care, diabetic education, acupuncture, travel benefit, breast pumps, mammograms, and preventive health and well-child are covered before you meet your deductible.</td>
<td>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 <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$4,000 person / $8,000 family Prescription drug limit: $1,650 person / $3,300 family</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billed charges, and health care this plan doesn’t cover</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.bcbsmt.com">www.bcbsmt.com</a> or call 1-855-322-4953 for a list of participating providers.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. 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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td></td>
<td></td>
<td>- Virtual visits available through MDLIVE: $50 copay; deductible does not apply.</td>
</tr>
<tr>
<td></td>
<td>Primary care visit to treat an injury or illness</td>
<td>In-Network Provider (you will pay the least): $50 copay/visit; deductible does not apply</td>
<td>Out-of-Network Provider (you will pay the most): 50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$50 copay/visit; deductible does not apply</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Charge; deductible does not apply</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>50% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>50% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Preferred generic drugs</td>
<td>Retail: $10 copay; Mail: $20 copay; deductible does not apply</td>
<td>Retail: $10 copay; deductible does not apply</td>
</tr>
<tr>
<td></td>
<td>Non-preferred generic drugs</td>
<td>Retail: $30 copay; Mail: $60 copay; deductible does not apply</td>
<td>Retail: $30 copay; deductible does not apply</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>Retail: $50 copay; Mail: $100 copay; deductible does not apply</td>
<td>Retail: $50 copay; deductible does not apply</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>Retail: $150 copay; Mail: $300 copay; deductible does not apply</td>
<td>Retail: $150 copay; deductible does not apply</td>
</tr>
<tr>
<td></td>
<td>Preferred specialty drugs</td>
<td>Retail: $150 copay; deductible does not apply</td>
<td>Retail: $150 copay; deductible does not apply</td>
</tr>
<tr>
<td></td>
<td>Non-preferred specialty drugs</td>
<td>Retail: $300 copay; deductible does not apply</td>
<td>Retail: $300 copay; deductible does not apply</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at [www.MUSTbenefits.org](http://www.MUSTbenefits.org).
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>50% coinsurance</td>
<td>Preauthorization required.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care</td>
<td>50% coinsurance</td>
<td>The plan pays the first $500 of eligible expenses for accident injuries; deductible and coinsurance waived.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$50 copay/visit; deductible does not apply</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>50% coinsurance</td>
<td>Preauthorization required.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>$50 copay/visit; deductible does not apply</td>
<td>First 3 visits per plan year not subject to deductible and coinsurance. Subsequent visits $50 copay per visit.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>50% coinsurance</td>
<td>Preauthorization required.</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>$50 copay/visit; deductible does not apply</td>
<td>Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>50% coinsurance</td>
<td>Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>50% coinsurance</td>
<td>Preauthorization required.</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay In-Network Provider (you will pay the least)</th>
<th>What You Will Pay Out-of-Network Provider (you will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>50% coinsurance</td>
<td>50% coinsurance</td>
<td>180 day combined maximum for home health care and hospice. Preauthorization required.</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>50% coinsurance</td>
<td>50% coinsurance</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Habilitation services</td>
<td>50% coinsurance</td>
<td>50% coinsurance</td>
<td>No Applied Behavior Analysis (ABA) benefits for Autism Spectrum Disorder available for members 19 years of age or older.</td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>50% coinsurance</td>
<td>50% coinsurance</td>
<td>60 days maximum per benefit period. Preauthorization required.</td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>50% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Hospice services</td>
<td>50% coinsurance</td>
<td>50% coinsurance</td>
<td>180 day combined maximum for home health care and hospice. Preauthorization required.</td>
<td></td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>No Charge; deductible does not apply</td>
<td>No Charge; deductible does not apply</td>
<td>Limited to 1 exam per benefit plan year.</td>
</tr>
<tr>
<td>Children’s glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at www.MUSTbenefits.org.
### Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Bariatric surgery</td>
</tr>
<tr>
<td>• Cosmetic surgery</td>
</tr>
<tr>
<td>• Dental care (Adult)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acupuncture</td>
</tr>
<tr>
<td>• Chiropractic care</td>
</tr>
</tbody>
</table>

---

**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](http://www.dol.gov/ebsa/healthreform), or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information 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](http://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](http://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](http://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:**


Navajo (Dine): Dinékʼehgo shika atʼohwol ninisígo, kwįįjí hólneyʼ 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: $2,000
- Specialist copayment: $50
- Hospital (facility) coinsurance: 50%
- Other coinsurance: 50%

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$2,000</td>
<td>$50</td>
<td>$1,900</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $60

**The total Peg would pay is**: $4,010

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

- The plan’s overall deductible: $2,000
- Specialist copayment: $50
- Hospital (facility) coinsurance: 50%
- Other coinsurance: 50%

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$1,900</td>
<td>$1,400</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $60

**The total Joe would pay is**: $3,360

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

- The plan’s overall deductible: $2,000
- Specialist copayment: $50
- Hospital (facility) coinsurance: 50%
- Other coinsurance: 50%

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$1,600</td>
<td>$200</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $0

**The total Mia would pay is**: $1,800

The plan would be responsible for the other costs of these EXAMPLE covered services.
<table>
<thead>
<tr>
<th>Language</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arabic</td>
<td>إن كان لديك أي أسئلة حول الموارد والخدمات، كن على استعداد للحصول على ترجمة أو مساعدة أخرى. إذا كنت سمة أو خدمات، قالب كن على استعداد للحصول على ترجمة أو مساعدة أخرى.</td>
</tr>
<tr>
<td>Burmese</td>
<td>မိုး၀န်နေရာ သို့မဟုတ် မြင်ရာသုံးစွဲချက်နှင့် ပတ်သက်သော ကွန်ပျူတာများကို ထူးထော်ပြီး။ စာသားဖို့ သာသနာချက်အားလုံးကို ထူးထော်ပြီး။</td>
</tr>
<tr>
<td>OWY Cherokee</td>
<td>၎င်းသည် တိုက်ခိုက်ရေး မှားသည်။ ၎င်းသည် တိုက်ခိုက်ရေး မှားသည်။</td>
</tr>
<tr>
<td>Chinese</td>
<td>如果您或您的亲朋好友对您的服务有疑问，请拨打电话至您的客服代表并询问电话号码。如果您不是会员或没有会员卡，请拨打855-710-6984。</td>
</tr>
<tr>
<td>Français</td>
<td>Si vous avez des questions, vous avez le droit de demander de l'aide et de 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 appeler le 855-710-6984.</td>
</tr>
<tr>
<td>Deutsch</td>
<td>Falls Sie 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 Kundenservice Nummer auf der Rückseite Ihrer Mitgliedskarte an. Für Fragen an die Kundenservice Nummer, rufen Sie bitte 855-710-6984 an.</td>
</tr>
<tr>
<td>Hinnoo</td>
<td>Yog koy, los yog lej tus neeg uas kog pas ntwam muj lus nrog bog. Koj muaj ca hais kom laww pas mbaab cov ntaub ntwam sau ua kum hou lus mok dawb rau koj. Xav tham eroj ib tag kws txhas lus, hu raus nas rpaw sbuexog pas cuam neeg thuas uas nyo sb tom mab ntwam kou daim nrau bsw cuab. Yog koy tus ysg ib tag ntwam bsw cuab, los yog ysg tus muaj nrau, hu raus 855-710-6984.</td>
</tr>
<tr>
<td>한국어</td>
<td>한국어 사용자들은 서비스를 이용해 결제를 할 수 있습니다. 서비스 이용에 대한 문의사항은 855-710-6984로 문의해 주세요.</td>
</tr>
<tr>
<td>Latvian</td>
<td>루트어에 서는 고객에게 서비스를 제공하는 것이 불가능합니다. 루트어의 경우, 세부 내용을 알아보기 위해서는 855-710-6984로 문의해 주세요.</td>
</tr>
<tr>
<td>Diny Navajo</td>
<td>T'ahni, eé doodago ba'da bii'anaanhoo'igil, na'ëlidge, ts'idi bee bii ahóon'ii t'áah nii'ëk a'ídoowl. Aa'í halne'í bích'i hagedozhí nízmíngíí kwe'é da'ínshíghi'í ákinaałwóó'igil bích'i hódlízhí, bee něhozhíí bina'óó 'déé' bích'i. Koji ah tsaazhoo'í ná hidi'ëego'í eé doodago bee něhozhíí ádëhí kóhóo'í hódlízhí. 855-710-6984.</td>
</tr>
<tr>
<td>فارسی</td>
<td>درج شده است نام‌گذاری که اشاره به کلمه می‌کند، سوالات به شدت تنها تا آن زمان خود، به طور رایانه‌ای، می‌تواند و اطلاعات مناسب را بازیابی کند. جهت کتاب‌ها، به اطلاعات مناسب، به خدمات متفرق، به نام‌های کتاب‌های گوناگون، به نام‌های کتاب‌های گوناگون، جهت کتاب‌های گوناگون، به نام‌های کتاب‌های گوناگون، به نام‌های کتاب‌های گوناگون، 855-710-6984.</td>
</tr>
<tr>
<td>Español</td>
<td>Si usted alguna vez se ha hablado español, sabe que estamos en un ambiente donde se puede hablar español. Eso significa que podemos hablar español. Para hablar con un intérprete comuniquese 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 855-710-9984.</td>
</tr>
<tr>
<td>Tagalog</td>
<td>Kung ikaw, o ang isang taong iyong tinitulungan ay may mga tanong, may karapatang kag makakau ng tungkong ito at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasisalin-wika, tawag sa numero ng serbisyo para sa kusotero sa likod ng iyong kard. Kung ikaw ay hindi isang miyembro, o kaya ay walang kard, tawag sa 855-710-6984.</td>
</tr>
<tr>
<td>Thai</td>
<td>หากคุณต้องการให้การสนับสนุนหรือการช่วยเหลือในภาษาอังกฤษ คุณสามารถติดต่อเราได้โดยตรงที่ 855-710-6984 คุณสามารถติดต่อเราได้โดยตรงที่ 855-710-6984.</td>
</tr>
<tr>
<td>Urdu</td>
<td>گرچکہ، کہ ہم ایک ویڈیو کے ذریعے ہمہ ایک یہ کہا ہے کہ ہمہ ایک یہ کہا ہے کہ ہمہ ایک یہ کہا ہے کہ ہمہ ایک یہ کہا ہے کہ ہمہ ایک یہ کہا ہے کہ ہمہ ایک یہ کہا ہے کہ ہمہ ایک یہ کہا ہے کہ ہمہ ایک یہ کہا ہے کہ ہمہ ایک یہ کہا ہے کہ ہمہ ایک یہ کہا ہے کہ ہمہ ایک یہ کہا ہے کہ ہمہ ایک یہ کہا ہے کہ 855-710-6984.</td>
</tr>
<tr>
<td>Tiếng Việt</td>
<td>Nếu quý vị hoặc người mà quý vị giúp đỡ đã biết kỹ thuật hỗ trợ, 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 miễn phí tại hỗ trợ và nhận thông tin của quý vị. Nếu quý vị không phải là hỗ trợ hoặc không có thể, gọi số 855-710-9984.</td>
</tr>
</tbody>
</table>

bcbsmt.com
**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.

<table>
<thead>
<tr>
<th>Office of Civil Rights Coordinator</th>
<th>Phone: 855-664-7270 (voicemail)</th>
</tr>
</thead>
<tbody>
<tr>
<td>300 E. Randolph St.</td>
<td>TTY/TDD: 855-661-6965</td>
</tr>
<tr>
<td>35th Floor</td>
<td>Fax: 855-661-6960</td>
</tr>
<tr>
<td>Chicago, Illinois 60601</td>
<td>Email: <a href="mailto:CivilRightsCoordinator@hcsc.net">CivilRightsCoordinator@hcsc.net</a></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>U.S. Dept. of Health &amp; Human Services</th>
<th>Phone: 800-368-1019</th>
</tr>
</thead>
<tbody>
<tr>
<td>200 Independence Avenue SW</td>
<td>TTY/TDD: 800-537-7697</td>
</tr>
<tr>
<td>Room 509F, HHH Building 1019</td>
<td>Complaint Portal: <a href="https://ocrportal.hhs.gov/ocr/portal/lobby.jsf">https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</a></td>
</tr>
</tbody>
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