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 http://chibenefitplans.net or call your local HR. 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.healthcare.gov/sbc-glossary or call your local HR to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	CommonSpirit Health Facility: **$0** individual /**$0** family per calendar year In-Network Provider: **$1,750** individual /**$3,500** family per calendar year Out-of-Network Provider: **$3,500** individual /**$7,000** family per calendar year	Generally, you must pay all 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. Well-child care, your drug costs, first colonoscopy and mammogram of the benefit period, ambulance services, in-network mental health/substance abuse, in-network office services, preventive care, and services subject to copayments 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?	CommonSpirit Health Facility: **$3,750** individual /**$7,500** family per calendar year In-Network Provider: **$3,750** individual /**$7,500** family per calendar year Out-of-Network Provider: **$12,000** individual /**$24,000** family per calendar year	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, pre-service review penalties, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. You have two levels for network providers. Enhanced Network Level: CommonSpirit Health Facilities In-Network Level: PPO see www.bcbsil.com/chi or call 866.776.4244 for a list of network providers.	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.
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
		CommonSpirit Health Facility (You will pay the least)	In-Network Provider (You will pay more)	Out-of- Network 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	Not applicable	25% coinsurance Deductible does not apply	60% coinsurance	Primary Care Physicians (PCP) are defined as General and Family Practice, Internal Medicine, Midwives, OB/GYN, Pediatricians, Nurse Practitioners, and PAs.
	Specialist visit	Not applicable	30% coinsurance Deductible does not apply	60% coinsurance	Applies to Non-PCP provider types. Chiropractic services apply deductible and coinsurance.
	Preventive care/screening/ immunization	No charge Deductible does not apply	No charge Deductible does not apply	No charge Deductible does not apply	See www.healthcare.gov for preventive care guidelines. There may be additional benefits available. See your Employer Summary Plan Description for details. 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.
If you have a test	Diagnostic test (x-ray, blood work)	Physician: N/A Facility: 15% coinsurance Deductible does not apply	30% coinsurance	60% coinsurance	For a test in a provider's office or clinic, your cost is included in the cost-share listed above. Waive coinsurance on first mammogram and colonoscopy of the benefit period.
	Imaging (CT/PET scans, MRIs)	Physician: N/A Facility: 15% coinsurance Deductible does not apply	30% coinsurance	60% coinsurance	For a test in a provider's office or clinic, your cost is included in the cost-share listed above.

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
		CommonSpirit Health Facility (You will pay the least)	In-Network Provider (You will pay more)	Out-of- Network 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.cap-rx.com For specialty prescriptions, go to www.dignityhealth.org/arizona/locations/stjosephs/services/pharmacy	Generic drugs	Retail: $5 copay Home delivery: $12.50 copay Deductible does not apply	Retail: $10 copay Home delivery: $25 copay Deductible does not apply	Retail: 60% coinsurance Deductible does not apply Home delivery: N/A	Covers up to a 30-day supply from an in- network retail pharmacy or a 90-day supply from a home delivery pharmacy. If you fill a brand-name prescription when a generic equivalent is available, you will pay the brand-name coinsurance plus the difference between the generic and brand-name. Maintenance medications must be filled for a 90-day supply using a CommonSpirit Health-owned pharmacy, the CommonSpirit Health home delivery pharmacy, the Capital Rx home delivery pharmacy, or a Walgreens retail pharmacy. Any combination of diabetic supplies and insulin purchased at a network retail pharmacy on the same day are subject to one copayment or the applicable coinsurance amount. Additional copayment / coinsurance amounts will apply to any combination of supplies purchased separately from an insulin purchase. Specialty prescriptions must be processed through the CommonSpirit Health Specialty Pharmacy. If the CommonSpirit Health Specialty Pharmacy can't fill your medication, your prescription will be routed to the Capital Rx Specialty Pharmacy partner or you may call 1.844.306.6254.
	Preferred brand drugs	15% coinsurance Retail: $20 min/$55 max Home delivery: $50 min/$87.50 max Deductible does not apply	30% coinsurance Retail: $40 min/$110 max Home delivery: $100 min/$175 max Deductible does not apply	Retail: 60% coinsurance Deductible does not apply Home delivery: N/A	
	Non-preferred brand drugs	25% coinsurance Retail: $32.50 min/$80 max Home delivery: $80 min/$162.50 max Deductible does not apply	50% coinsurance Retail: $65 min/$160 max Home delivery: $160 min/$325 max Deductible does not apply	Retail: 60% coinsurance Deductible does not apply Home delivery: N/A	
	Specialty drugs	Refer to above costs	Refer to above costs	Refer to above costs	

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
		CommonSpirit Health Facility (You will pay the least)	In-Network Provider (You will pay more)	Out-of- Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance Deductible does not apply	30% coinsurance	60% coinsurance	Waive coinsurance on first colonoscopy of the benefit period.
	Physician/ surgeon fees	Not applicable	30% coinsurance	60% coinsurance	None
If you need immediate medical attention	Emergency room care	$200 copay per facility per date of service for facility and physician(s) services combined Deductible does not apply	$200 copay per facility per date of service for facility and physician(s) services combined Deductible does not apply	$200 copay per facility per date of service for facility and physician(s) services combined Deductible does not apply	50% coinsurance applies to non-emergency medical services. For emergency medical conditions treated out-of-network, you may be balance billed. Dental treatment for accidental injury is limited to care completed within 12 months of the injury.
	Emergency medical transportation	No charge Deductible does not apply	No charge Deductible does not apply	No charge Deductible does not apply	Ambulance services received from an out-of-network provider may balance bill the difference in the billed amount and the allowed amount.
	Urgent care	$75 copay per provider per date of service Deductible does not apply	$75 copay per provider per date of service Deductible does not apply	$75 copay per provider per date of service Deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance Deductible does not apply	30% coinsurance	60% coinsurance	Reduction for failure to pre-certify out-of-network services is $500 per admission.
	Physician/ surgeon fees	Not applicable	30% coinsurance	60% coinsurance	None

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
		CommonSpirit Health Facility (You will pay the least)	In-Network Provider (You will pay more)	Out-of- Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Physician: N/A Facility: 15% coinsurance Deductible does not apply	30% coinsurance Deductible does not apply	60% coinsurance	None
	Inpatient services	Physician: N/A Facility: 15% coinsurance Deductible does not apply	30% coinsurance Deductible does not apply	60% coinsurance	Residential treatment is covered with no 24-hour nursing supervision requirement. Reduction for failure to pre-certify out-of-network services is $500 per admission.
If you are pregnant	Office visits	Not applicable	25% coinsurance (no deductible office visit only) All other physician services will apply to the deductible	60% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply to certain preventive services. Any in-network services that fall outside of preventive care/routine obstetric care, will pay at the most appropriate benefit in the plan document.
	Childbirth/ delivery professional services	Not applicable	30% coinsurance	60% coinsurance	Benefits shown reflect OB/GYN practitioner services which may be globally billed at time of delivery for pre-natal, post-natal and delivery services. Not all services are billed globally.
	Childbirth/ delivery facility services	15% coinsurance Deductible does not apply	30% coinsurance	60% coinsurance	None

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
		CommonSpirit Health Facility (You will pay the least)	In-Network Provider (You will pay more)	Out-of- Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	Physician: N/A 15% coinsurance Deductible does not apply	30% coinsurance	60% coinsurance	None
	Rehabilitation services	Physician: N/A Facility: 15% coinsurance Deductible does not apply	30% coinsurance	60% coinsurance	In-Network and Out-of-Network outpatient/office physical, speech and occupational therapies are limited to 30 combined visits per calendar year. CommonSpirit Health Facilities aka Enhanced Network is not subject to 30-visit maximum.
	Habilitation services	Physician: N/A Facility: 15% coinsurance Deductible does not apply	30% coinsurance	60% coinsurance	In-Network and Out-of-Network outpatient/office physical, speech and occupational therapies are limited to 30 combined visits per calendar year. CommonSpirit Health Facilities aka Enhanced Network is not subject to 30-visit maximum.
	Skilled nursing care	Physician: N/A Facility: 15% coinsurance Deductible does not apply	30% coinsurance	60% coinsurance	Reduction for failure to pre-certify out-of-network services is $500 per admission.
	Durable medical equipment	Not applicable	30% coinsurance	60% coinsurance	One wig per calendar year is covered when related to medical condition. 2 pair of foot orthotics covered per calendar year.
	Hospice services	Physician: N/A Facility: 15% coinsurance Deductible does not apply	30% coinsurance	60% coinsurance	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	Not covered	None

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.)

- Cosmetic Surgery
- Custodial care – in home or facility
- Dental care
- Eye exam
- Glasses
- Hearing aids
- Long-term care
- Massage Therapy
- Routine eye care – Adult
- Routine foot care
- Weight loss programs

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

- Acupuncture (10 visits per calendar year)
- Bariatric surgery
- Chiropractic care (20 visits per calendar year)
- Infertility treatment ($15,000 LTM, $5,000 LTM for infertility medications, excludes some services)
- Private-duty nursing – short-term intermittent home skilled nursing

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.S. Department of Labor, Employee Benefits Security Administration at 1.866.444.EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 on how 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: your local HR; Blue Cross and Blue Shield of Illinois at 1.866.766.4244 or visit www.bcbsil.com; or Employee Benefits Security Administration at 1.866.444.EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance at 1.877.527.9431 or visit http://insurance.illinois.gov.

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

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your 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.

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	**$1,750**
Specialist coinsurance	**25%**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**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)*

Total Example Cost	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,750
Copayments	$0
Coinsurance	$3,309
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,119**

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

The plan's overall deductible	**$1,750**
Primary care coinsurance	**25%**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**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)*

Total Example Cost	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,750
Copayments	$310
Coinsurance	$1,602
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$3,722**

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

The plan's overall deductible	**$1,750**
Emergency room copayment	**$200**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**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)*

Total Example Cost	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,750
Copayments	$200
Coinsurance	$18
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,968**

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

BlueCross BlueShield of Illinois

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.
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.
Ελληνικά Greek	Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να μιλήσετε σε έναν διερμηνέα, καλέστε τον αριθμό εξυπηρέτησης πελατών που αναγράφεται στο πίσω μέρος της κάρτας μέλους σας. Εάν δεν είστε μέλος ή δεν έχετε κάρτα, καλέστε τον αριθμό 855-710-6984.
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 કૉલ કરો. જો આપ સભ્યપદ ના ધરાવતા હોવ, અથવા આપની પાસે કાર્ડ નથી તો 855-710-6984 નંબર પર કૉલ 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।
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il servizio clienti al numero riportato sul lato posteriore della tua tessera di socio. Se non sei socio o non possiedi una tessera, puoi chiamare il numero 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.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, 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 áká anídaalwo'ígíí bich'į' hodíílnih, bee nééhózinii bine'dęę' bikáá'. Kojí atah naaltsoos ná hadít'éégóó éí doodago bee nééhózinígíí ádingo kojį' hodíílnih 855-710-6984.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer podany na odwrocie karty członkowskiej. Jeżeli nie jesteś członkiem lub nie masz przy sobie karty, zadzwoń pod numer 855-710-6984.
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	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