

 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 [azblue.com/GroupPlanDoc2019](https://azblue.com/GroupPlanDoc2019) or call 1-877-475-8440. 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 [healthcare.gov/sbc-glossary](https://healthcare.gov/sbc-glossary) or by calling 1-877-475-8440 to request a copy.

Important Questions	Answers	Why this Matters:
<b>What is the overall deductible?</b>	<p><u>In-network providers</u>: <b>\$500/member</b> and <b>\$1,000/family</b></p> <p><u>Out-of-network providers</u>: <b>\$1,000/member</b> and <b>\$2,000/family</b></p>	<p>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>. Unless a <u>copay</u>, fee, or other percent is shown, the <u>coinsurance</u> percent of the <u>allowed amount</u> that you pay for most services is 10% <u>in-network</u> and 50% <u>out-of-network</u>.</p>
<b>Are there services covered before you meet your deductible?</b>	<p>Yes. <u>In-network</u>: <u>primary care</u> and <u>specialist</u> office visits, <u>preventive services</u>; <u>prescription drugs</u>, <u>urgent care</u> visits, child eye exams; children's eyeglasses; and children's dental check-ups are covered before you meet your <u>deductible</u>.</p> <p><u>In-network</u> and <u>out-of-network</u>: <u>emergency medical transportation</u>, and hospice services are covered before you meet your <u>deductible</u>.</p>	<p>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.</p> <p>For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u>. See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<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 <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	<p><u>In-network providers</u>: <b>\$2,000/member</b> and <b>\$4,000/family</b></p> <p><u>Out-of-network providers</u>: <b>\$4,000/member</b> and <b>\$8,000/family</b></p>	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premiums</u> , <u>out-of-network</u> precertification penalty charges, <u>balance bills</u> , and costs for 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> .

Important Questions	Answers	Why this Matters:
<b>Will you pay less if you use an <u>in-network provider</u>?</b>	Yes. See <a href="http://www.azblue.com">www.azblue.com</a> or call 1-877-475-8440 for a list of <u>in-network providers</u> .	This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's 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 <u>referral</u> to see a <u>specialist</u>?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <u>provider's</u> office or clinic</b>	<u>Primary care</u> visit to treat an injury or illness	\$15 <u>copay</u> / <u>provider</u> /day, <u>deductible</u> does not apply	50% <u>coinsurance</u> & <u>balance bill</u>	<u>Specialist copay</u> for most chiropractic services. Some drugs administered during an office visit may require precertification. \$10 <u>copay</u> for medical telehealth consultations through BlueCare Anywhere.
	<u>Specialist</u> visit	\$30 <u>copay</u> / <u>provider</u> /day, <u>deductible</u> does not apply		
	<u>Preventive care/screening/immunization</u>	No charge		
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	Office visit <u>copay</u> ( <u>deductible</u> does not apply) or 10% <u>coinsurance</u>	50% <u>coinsurance</u> & <u>balance bill</u>	<u>Cost share</u> varies based on place of service and <u>provider's network</u> status & type. Precertification required for some imaging services. \$500 charge if no precertification obtained for some <u>out-of-network</u> services.
	Imaging (CT/PET scans, MRIs)			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.azblue.com">www.azblue.com</a>	<u>Generic drugs</u> (Level 1)	\$5 <u>copay</u> /30 day supply, <u>deductible</u> does not apply	\$5 <u>copay</u> /30 day supply & <u>balance bill</u> , <u>deductible</u> does not apply	Mail order, <u>Specialty</u> , and 90-day retail supplies of drugs are not covered <u>out-of-network</u> . 90-day supply costs 3 <u>copays</u> (retail pharmacy) or 2 <u>copays</u> (mail order). If generic available, member pays level 1 <u>copay</u> + price difference for brand drug. Some drugs require precertification and won't be covered without it. Only <u>formulary</u> drugs are covered unless a <u>formulary</u> exception is approved.
	Preferred <u>brand drugs</u> (Level 2)	\$20 <u>copay</u> /30 day supply, <u>deductible</u> does not apply	\$20 <u>copay</u> /30 day supply & <u>balance bill</u> , <u>deductible</u> does not apply	
	Non-preferred <u>brand drugs</u> (Level 3)	\$40 <u>copay</u> /30 day supply, <u>deductible</u> does not apply	\$40 <u>copay</u> /30 day supply & <u>balance bill</u> , <u>deductible</u> does not apply	
	<u>Specialty drugs</u>	50% <u>coinsurance</u> , <u>deductible</u> does not apply	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	50% <u>coinsurance</u> & <u>balance bill</u>	Precertification required for some outpatient services and drugs. \$500 charge if no precertification obtained for some <u>out-of-network</u> services. Additional \$1,000 access fee for all bariatric surgeries.
	Physician/surgeon fees			
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	10% <u>coinsurance</u>		None.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u> , <u>deductible</u> does not apply		
	<u>Urgent care</u>	\$60 <u>copay</u> /provider/day, <u>deductible</u> does not apply	50% <u>coinsurance</u> & <u>balance bill</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	50% <u>coinsurance</u> & <u>balance bill</u>	Precertification required for some non-emergency services and drugs. \$500 charge, if no precertification for <u>out-of-network</u> stay. Additional \$1,000 access fee for all bariatric surgeries.
	Physician/surgeon fee			
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient Services	Copay applies to office, home, walk-in clinic visits ( <u>deductible</u> does not apply). Amount varies based on PCP/Specialist. 10% <u>coinsurance</u> applies to all other locations.	50% <u>coinsurance</u> & <u>balance bill</u>	<u>Cost share</u> varies based on place of service and provider's <u>network</u> status & type. \$20 <u>copay</u> for counseling or \$30 <u>copay</u> for psychiatric telehealth consultation through BlueCare Anywhere.
	Inpatient Services	10% <u>coinsurance</u>	50% <u>coinsurance</u> & <u>balance bill</u>	Precertification required. \$500 charge if no precertification for <u>out-of-network</u> services.
<b>If you are pregnant</b>	Office visits	Office visit <u>copay</u> , <u>deductible</u> does not apply	50% <u>coinsurance</u> & <u>balance bill</u>	Only 1 <u>copay</u> is collected for services included in delivering physician's global charge. Depending on type of services, <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in SBC (i.e. ultrasound). <u>Cost sharing</u> does not apply for <u>in-network preventive services</u> .
	Childbirth/delivery professional services	10% <u>coinsurance</u>	50% <u>coinsurance</u> & <u>balance bill</u>	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	50% <u>coinsurance</u> & <u>balance bill</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u> /Home infusion therapy	10% <u>coinsurance</u>	50% <u>coinsurance</u> & <u>balance bill</u>	Precertification required. \$500 charge if no precertification for <u>out-of-network</u> services. Limit of 42 visits (of up to 4 hours)/calendar year.
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	50% <u>coinsurance</u> & <u>balance bill</u>	Precertification required for inpatient facility admission. \$500 charge if precertification not obtained for <u>out-of-network</u> admission. Annual limits: 90 inpatient days for Extended Active Rehabilitation Facility (EAR) and Skilled Nursing Facility (SNF) combined, and a 60-visit limit each for outpatient <u>rehabilitative</u> and <u>habilitative</u> services.
	<u>Habilitation services</u>	10% <u>coinsurance</u>	50% <u>coinsurance</u> & <u>balance bill</u>	
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	50% <u>coinsurance</u> & <u>balance bill</u>	
	<u>Durable medical equipment</u>	Office visit <u>copay</u> ( <u>deductible</u> does not apply) or 10% <u>coinsurance</u>	50% <u>coinsurance</u> & <u>balance bill</u>	<u>Cost share</u> varies based on place of service and <u>provider's network</u> status & type.
	<u>Hospice services</u>	No charge	No charge except <u>balance bill</u> , <u>deductible</u> does not apply	None.
<b>If your child needs dental or eye care</b>	Children's eye exam	\$15 <u>copay</u> /visit, <u>deductible</u> does not apply	50% <u>coinsurance</u> & <u>balance bill</u>	Limit of 1 routine vision exam/calendar year. No charge for member under age 5.
	Children's glasses	No charge	Not covered	Limit of 1 pair of glasses or contact lenses/calendar year.
	Children's dental check-up	No charge	No charge except <u>balance bill</u> , <u>deductible</u> does not apply	Limit of 2 dental check-ups & cleanings/calendar year.

## 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.)

- |   |  |   |
|---|--|---|
| • Acupuncture   | • Eyewear except as stated in <u>plan</u>                              | • Private-duty nursing, except when <u>medically necessary</u> or when <u>skilled nursing</u> not available |
| • Adult routine vision exam   | • Fertility and infertility medication and treatment                   | • Respite care  |
| • Alternative medicine  | • Flat feet treatment and services                                     | • Routine foot care   |
| • Care that is not <u>medically necessary</u>                                 | • Genetic and chromosomal testing, except as stated in <u>plan</u>     | • Sexual dysfunction treatment and services   |
| • Cosmetic surgery, cosmetic services & supplies                              | • Long-term care, except long-term acute care                          | • Weight loss programs  |
| • Custodial care  | • Massage therapy other than allowed under medical coverage guidelines |   |
| • Dental care and orthodontic services (Adult) except as stated in plan       | • Orthodontic services (Pediatric) that are not dentally necessary     |   |
| • <u>DME</u> rental/repair charges that exceed <u>DME</u> allowed amount      |  |   |
| • Experimental and investigational treatments except as stated in <u>plan</u> |  |   |

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

- |                     |  |   |
|---------------------|--|---|
| • Bariatric surgery | • Hearing aids, up to 1 per ear, per calendar year | • Non-emergency care when travelling outside the U.S. |
| • Chiropractic care |  |   |

**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:

- For group health coverage subject to ERISA, contact the 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).
- For non-federal governmental group health plans, contact the 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).
- Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact the Arizona Department of Insurance (602-364-2499, or 1-800-325-2548 in Arizona but outside the Phoenix area) regarding their possible rights to continuation coverage under State law.

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:

- For group health coverage subject to ERISA, contact Blue Cross Blue Shield of Arizona at 1-877-475-8440. You may also contact the 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). If your coverage is insured, you may also contact the Arizona Department of Insurance at 602-364-2499, or 1-800-325-2548 in Arizona but outside the Phoenix area.
- For non-federal governmental group health plans and church plans that are group health plans, contact Blue Cross Blue Shield of Arizona at 1-877-475-8440. If your coverage is insured, you may also contact the Arizona Department of Insurance at 602-364-2499, or 1-800-325-2548 in Arizona but outside the Phoenix area.

#### **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 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 <u>deductible</u>	\$500
■ <u>Specialist copayment</u>	\$30
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$80
<u>Coinsurance</u>	\$950
<i>What isn't covered</i>	
Limits or <u>exclusions</u>	\$60
<b>The total Peg would pay is</b>	<b>\$1,590</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall <u>deductible</u>	\$500
■ <u>Specialist copayment</u>	\$30
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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#### In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$110
<u>Copayments</u>	\$560
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or <u>exclusions</u>	\$60
<b>The total Joe would pay is</b>	<b>\$730</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall <u>deductible</u>	\$500
■ <u>Specialist copayment</u>	\$30
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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#### In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$60
<u>Coinsurance</u>	\$110
<i>What isn't covered</i>	
Limits or <u>exclusions</u>	\$0
<b>The total Mia would pay is</b>	<b>\$670</b>

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



## Multi-language Interpreter Services

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue Cross Blue Shield of Arizona, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 602-864-4884.

Navajo: Dii kwe'é atah nilínigíí Blue Cross Blue Shield of Arizona haada yit'éego bína'idíłkido éí doodago Háida bį́jį anilyeedígíí t'áadoo le'é yina'idíłkido beehaz'áanii hółó díí t'áa hazaadk'ehjí háká a'doowotgo bee haz'á doo bą́ąh ílínígóó. Ata' halne'ígíí kojį' bich'į' hodíilnih 877-475-4799.

Chinese: 如果您，或是您正在協助的對象，有關於插入項目的名稱 Blue Cross Blue Shield of Arizona 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 在此插入數字 877-475-4799。

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue Cross Blue Shield of Arizona quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 877-475-4799.

Arabic:

إن كان لديك أو لدى شخص تساعد أسئلة بخصوص Blue Cross Blue Shield of Arizona، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 877-475-4799.

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Blue Cross Blue Shield of Arizona, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 877-475-4799.

**Korean:** 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Blue Cross Blue Shield of Arizona 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 877-475-4799 로 전화하십시오.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue Cross Blue Shield of Arizona, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 877-475-4799.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue Cross Blue Shield of Arizona haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 877-475-4799 an.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue Cross Blue Shield of Arizona, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 877-475-4799.

Japanese: ご本人様、またはお客様の身の回りの方でも、Blue Cross Blue Shield of Arizona について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、情報を入手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、877-475-4799 までお電話ください。

Farsi:

اگر شما، یا کسی که شما به او کمک میکنید، سوال در مورد Blue Cross Blue Shield of Arizona، داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. 877-475-4799 تماس حاصل نمایید.

Assyrian:

[illegible]

Serbo-Croatian: Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Blue Cross Blue Shield of Arizona, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 877-475-4799.

Thai: หากคน หรือคนที่คุณกำลังช่วยเหลือมีคำถามเกี่ยวกับ Blue Cross Blue Shield of Arizona  
คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับ ล่าม โทร 877-475-4799

Blue Cross Blue Shield of Arizona (BCBSAZ) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BCBSAZ provides appropriate free aids and services, such as qualified interpreters and written information in other formats, to people with disabilities to communicate effectively with us. BCBSAZ also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, call (602) 864-4884 for Spanish and 1 (877) 475-4799 for all other languages and other aids and services.

If you believe that BCBSAZ has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: BCBSAZ's Civil Rights Coordinator, Attn: Civil Rights Coordinator, Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466, (602) 864-2288, TTY/TDD (602) 864-4823, [crc@azblue.com](mailto:crc@azblue.com). You can file a grievance in person or by mail or email. If you need help filing a grievance, BCBSAZ's Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1 (800) 368-1019, 1 (800) 537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.