Coverage Period: 07/01/2023 – 06/30/2024 Coverage for: Individual + Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 1-800-942-5837 or at <a href="https://www.bcbsok.com">www.bcbsok.com</a>. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms, see the Glossary. You can view the Glossary at <a href="https://www.healthcare.gov/sbc-glossary/">www.healthcare.gov/sbc-glossary/</a> or call 1-855-756-4448 to request a copy.

| Important Questions   | Answers  | Why This Matters:   |
|---|--|---|
| What is the overall deductible?   | Network: \$500 Individual / \$1,500 Family Out-of-Network: \$500 Individual / \$1,500 Family   | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .   |
| Are there services covered before you meet your deductible?                 | Yes. Services that charge a <u>copay</u> , <u>prescription drugs</u> , ambulance, certain <u>preventive care</u> , and <u>Network</u> <u>diagnostic tests</u> are covered before you meet your <u>deductible</u> .     | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <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 <u>www.healthcare.gov/coverage/preventive-care-benefits/</u> .   |
| Are there other deductibles for specific services?                          | No.  | You don't have to meet <u>deductibles</u> for specific services.  |
| What is the <u>out-of-</u><br><u>pocket limit</u> for this<br><u>plan</u> ? | Blue Preferred: \$2,500 Individual / \$7,500 Family Blue Choice: \$3,500 Individual / \$8,700 Family Out-of-Network: \$5,500 Individual / \$16,500 Family Prescription drug limit: \$1,500 Individual / \$4,500 Family | 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.   |
| What is not included in the out-of-pocket limit?                            | Premiums, balance-billing charges, preauthorization penalties, 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 <u>network</u> <u>provider</u> ?             | Yes. See <u>www.bcbsok.com</u> or call 1-800-942-5837 for a list of <u>Network providers</u> .   | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's 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 <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u> ?                  | No.  | You can see the specialist you choose without a referral.   |

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All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common   |  | What You Will Pay   |   | Limitations, Exceptions, & Other  |  |
|--|--|---|---|---|--|
| Medical Event  | Services You May Need                            | Network Provider<br>(You will pay the least)                  | Out-of-Network Provider (You will pay the most)             | Important Information   |  |
| The second space of the se | Primary care visit to treat an injury or illness | \$30 <u>copay</u> /visit;<br><u>deductible</u> does not apply | \$30 copay/visit;<br>deductible does not apply              | None  |  |
| If you visit a health care provider's  | <u>Specialist</u> visit                          | \$30 <u>copay</u> /visit;<br><u>deductible</u> does not apply | \$30 copay/visit;<br>deductible does not apply              | None  |  |
| office or clinic   | Preventive care/screening/<br>immunization       | No Charge;<br>deductible does not apply                       | \$30 <u>copay</u> /visit plus<br>50% <u>coinsurance</u>     | You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. |  |
| If you have a test   | Diagnostic test (x-ray, blood work)              | No Charge; deductible does not apply                          | 50% coinsurance   | In conjunction with office visit, No Charge after visit copay.  |  |
|  | Imaging (CT/PET scans, MRIs)                     | 20%/30% coinsurance   | 50% coinsurance   | None  |  |
| I.E.   | Generic drugs                                    | 30% coinsurance;<br>deductible does not apply                 | 30% <u>coinsurance;</u><br><u>deductible</u> does not apply | Prescription drug out-of-pocket limit:<br>\$1,500 Individual / \$4,500 Family   |  |
| If you need drugs<br>to treat your illness<br>or condition   | Preferred brand drugs                            | \$25 copay/prescription;<br>deductible does not apply         | \$25 copay/prescription;<br>deductible does not apply       | Minimum \$12 copay for generic drugs. Minimum \$25 copay for non-preferred  |  |
| More information about prescription  | Non-preferred brand drugs                        | 30% <u>coinsurance;</u> <u>deductible</u> does not apply      | 30% <u>coinsurance;</u> <u>deductible</u> does not apply    | brand and specialty drugs.  All Out-of-Network prescriptions subject to additional 20% penalty.   |  |
| drug coverage is available at www.bcbsok.com/me mber/prescriptiondrug s.html   | Specially office                                 | 30% coinsurance;  | 30% coinsurance;  | Retail limited to 30-day supply. Mail order limited to 90-day supply of maintenance drugs at 3X copay amount.   |  |
|  |  | deductible does not apply                                     | deductible does not apply                                   | Specialty drugs are available at any retail pharmacy. Limited to 30-day supply. Mail order is not covered.  |  |

<sup>\*</sup> For more information about limitations and exceptions, see the  $\underline{\text{plan}}$  or policy document at  $\underline{\text{www.bcbsok.com}}$ .

| Common<br>Medical Event                                | Services You May Need                          | What You<br><u>Network Provider</u><br>(You will pay the least)   | ı Will Pay<br><u>Out-of-Network Provider</u><br>(You will pay the most) | Limitations, Exceptions, & Other<br>Important Information   |
|--|--|---|---|---|
| If you have  | Facility fee (e.g., ambulatory surgery center) | 20%/30% coinsurance   | 50% <u>coinsurance</u>  | Elective abortion is not covered.   |
| outpatient surgery                                     | Physician/surgeon fees                         | 20%/30% coinsurance   | 50% coinsurance   | None  |
| If you need  | Emergency room care                            | 20% coinsurance   | 20% coinsurance   | Additional \$100 copay per visit; waived if admitted.  Non-emergency use of ER: 20%/30% coinsurance In-Network, 50% coinsurance Out-of-Network. |
| immediate medical attention                            | Emergency medical transportation               | No Charge;<br>deductible does not apply   | No Charge;<br>deductible does not apply                                 | None  |
|  | Urgent care                                    | \$30 <u>copay</u> /visit;<br><u>deductible</u> does not apply   | \$30 <u>copay</u> /visit;<br><u>deductible</u> does not apply           | None  |
| If you have a  | Facility fee (e.g., hospital room)             | 20%/30% coinsurance   | 50% coinsurance   | Preauthorization required; \$500 penalty if not preauthorized Out-of-Network.   |
| hospital stay  | Physician/surgeon fees                         | 20%/30% coinsurance   | 50% coinsurance   | None  |
| If you need mental<br>health, behavioral<br>health, or | Outpatient services                            | \$30 copay/office visit;<br>deductible does not apply<br>20%/30% coinsurance for<br>other outpatient services | 50% coinsurance   | Preauthorization required for certain services.   |
| substance abuse services                               | Inpatient services                             | 20%/30% coinsurance   | 50% <u>coinsurance</u>  | Preauthorization required; \$500 penalty if not preauthorized Out-of-Network.   |

<sup>\*</sup> For more information about limitations and exceptions, see the  $\underline{\text{plan}}$  or policy document at  $\underline{\text{www.bcbsok.com}}$ .

| @   | What You Will Pay                         |   | Limitations, Exceptions, & Other                |   |
|---|---|---|---|---|
| Common<br>Medical Event   | Services You May Need                     | Network Provider<br>(You will pay the least)                  | Out-of-Network Provider (You will pay the most) | Important Information   |
| -elemente en en en esta del | Office visits                             | \$30 <u>copay</u> /visit;<br><u>deductible</u> does not apply | \$30 copay/visit;<br>deductible does not apply  | Copay applies to first prenatal visit (per pregnancy). Cost sharing does not apply for preventive   |
| If you are pregnant   | Childbirth/delivery professional services | 20%/30% <u>coinsurance</u>                                    | 50% <u>coinsurance</u>                          | 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 facility services     | 20%/30% coinsurance   | 50% coinsurance                                 | Preauthorization required; \$500 penalty if not preauthorized Out-of-Network.   |
|   | Home health care                          | 20%/30% coinsurance   | 50% coinsurance                                 | 30-visit limit per benefit period.  Preauthorization required; \$500 penalty if not preauthorized Out-of-Network.   |
|   | Rehabilitation services                   | 20%/30% coinsurance   | 50% <u>coinsurance</u>                          | Outpatient: Combined 25-visit limit per benefit period for physical, speech, and occupational therapies.  |
| If you need help<br>recovering or have<br>other special health  | Habilitation services                     | 20%/30% coinsurance   | 30% coinsurance 50% coinsurance Preauthoriza    | Inpatient: 30-day limit per benefit period. <u>Preauthorization</u> required; \$500 penalty if not preauthorized <u>Out-of-Network</u> .  |
| needs   | Skilled nursing care                      | 20%/30% coinsurance   | 50% <u>coinsurance</u>                          | 30-day limit per benefit period. <u>Preauthorization</u> required; \$500 penalty if not preauthorized <u>Out-of-Network</u> .   |
|   | Durable medical equipment                 | 20%/30% coinsurance   | 50% coinsurance                                 | Medically necessary rental or purchase at the plan's discretion.  |
|   | Hospice services                          | 20%/30% coinsurance   | 50% coinsurance                                 | <u>Preauthorization</u> required; \$500 penalty if not preauthorized <u>Out-of-Network</u> .  |
|   | Children's eye exam                       | Not Covered   | Not Covered                                     | None  |
| If your child needs dental or eye care                          | Children's glasses                        | Not Covered   | Not Covered                                     | None  |
| asima er oje oaro   | Children's dental check-up                | Not Covered   | Not Covered                                     | None  |

<sup>\*</sup> For more information about limitations and exceptions, see the  $\underline{\text{plan}}$  or policy document at  $\underline{\text{www.bcbsok.com}}$ .

## **Excluded Services & Other Covered Services:**

Hearing aids (one per ear every 48 months)

## 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
- Bariatric surgery
- Cosmetic surgery

- Dental care (Adult and child)
- Elective abortion (unless the life of the mother is endangered)
- Infertility treatment (diagnosis of infertility covered)
- Long-term care
- Routine eye care (Adult and child)
- Weight loss programs

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

Chiropractic care

- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

• Routine foot care (only for diabetic members)

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>plan</u> at 1-800-942-5837, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <a href="https://www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a>, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <a href="https://www.cciio.cms.gov">www.cciio.cms.gov</a>. Other coverage options may be available to you too, including buying individual insurance coverage through the <a href="https://www.healthCare.gov">Health Insurance</a> Marketplace. For more information about the <a href="https://www.healthCare.gov">Marketplace</a>, visit <a href="https://www.healthCare.gov">www.healthCare.gov</a> or call 1-800-318-2596

Your <u>Grievance</u> and <u>Appeals</u> Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the <u>explanation</u> of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: Blue Cross and Blue Shield of Oklahoma at 1-800-942-5837 or visit <u>www.bcbsok.com.</u>, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit <u>www.dol.gov/ebsa/healthreform</u>. Additionally, a consumer assistance program can help you file your <u>appeal</u>. Contact the Oklahoma Insurance Department at 1-800-522-0071 or visit <u>www.ok.gov/oid/Consumers/Consumer\_Assistance/</u>.

### 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.

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-942-5837.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-942-5837.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-942-5837.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-942-5837.

To see examples of how this <u>plan</u> 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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and excluded services under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

## Peg is Having a Baby

(9 months of <u>in-network</u> pre-natal care and a hospital delivery)

| ■ The plan's overall deductible | \$500 |
|---------------------------------|-------|
| ■ Specialist copayment          | \$30  |
| Hospital (facility) coinsurance | 20%   |
| Other coinsurance               | 20%   |

#### 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              | \$12,700 |
|---------------------------------|----------|
| In this example, Peg would pay: |          |
| <u>Cost sharing</u>             |          |
| <u>Deductibles</u>              | \$500    |
| Copayments                      | \$30     |
| Coinsurance                     | \$2,000  |
| What isn't covered              |          |
| Limits or exclusions            | \$60     |
| The total Peg would pay is      | \$2,560  |

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

| ■ The <u>plan's</u> overall <u>deductible</u> | \$500 |
|---|-------|
| Specialist copayment                          | \$30  |
| Hospital (facility) coinsurance               | 20%   |
| Other coinsurance                             | 20%   |

#### This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (*including disease education*)
Diagnostic tests (*blood work*)

Prescription drugs

**Total Example Cost** 

<u>Durable medical equipment</u> (glucose meter)

| <u>Cost sharing</u>        |         |
|----------------------------|---------|
| <u>Deductibles</u>         | \$500   |
| Copayments                 | \$800   |
| Coinsurance                | \$60    |
| What isn't covered         |         |
| Limits or exclusions       | \$20    |
| The total Joe would pay is | \$1,380 |

## Mia's Simple Fracture

(<u>in-network emergency room</u> visit and follow up care)

| The plan's overall deductible   | \$500 |
|---------------------------------|-------|
| Specialist copayment            | \$30  |
| Hospital (facility) coinsurance | 20%   |
| Other coinsurance               | 20%   |

#### This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (x-ray)

**Total Example Cost** 

\$5,600

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

| <u>Cost sharing</u>        |       |
|----------------------------|-------|
| <u>Deductibles</u>         | \$500 |
| <u>Copayments</u>          | \$200 |
| Coinsurance                | \$100 |
| What isn't covered         |       |
| Limits or exclusions       | \$0   |
| The total Mia would pay is | \$800 |

\$2,800

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.

| إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات العسرورية بلغلك من دون اية نكلفة. للنحدث إلى مفرجم فوري، انصل على رقم خدمة العملاء المدكور على ظهر يطافة عصويلك. فإن لم نكن عضوًا، أو<br>كنت لا تطلقة، فاتصل على 894-710-855.  |
|--|
| သင် သို့မဟုတ် သင်ကူညီပေးနေသူတဦးမှ မေးမြန်းလိုသည့် မေးခွန်းများရှိပါက သင့် ဘာသာစကားဖြင့် အကူအညီနှင့် အချက်အလက်များကို အခမဲ့ဖြင့်ရယူနိုင်သည့်အခွင့်အရေးရှိပါသ ည်။ ဘွာသာစကား<br>ပြန်ဆိုသူနှင့် စကားပြောရန် သင့် အဖွဲ့ ပင်ကဒ်၏ နောက်ကျောဖက်ပေါ် ရှိ သုံးစွဲသူ ပန်ဆောင်မှု ဖုန်းနပါတ်သို့ ခေါ်ဆိုပါ။ အကယ်၍ သင်သည် အဖွဲ့ ပင်တစ်ဦး မဟုတခဲ့ပါက သို့မဟုတ် ကဒ် မရှပါက 855-<br>710-6984 သို့ ခေါ်ဆိုပါ။   |
| h.JZ, D& YGT ፀ JOSPÆEY, ശേଟെ&ൽ\$, h.J C.J ፀጭሃ RCPÆSIJ D& RCZ4J CT GO h.J. EWOY D4V°V°. ፀጭሃZ DAPJÆY GÆL&ZPJT, ወෑ JbW°b ፀጭሃፀT O'hGÆY<br>DOLÆSPÆY ፀጭሃ PPT CT/P ኤJሮ DIhhÆJ SAÆIT J4ÆJ. APO hÞRO ኤY, D& DIhhÆJ hC©O ኤY, ወÆbWኖ\$ DJJh 855-710-6984.  |
| 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<br>會員卡, 請致電 855-710-6984。  |
| 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 interprête, 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.                    |
| 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.                          |
| 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 nyo b 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. |
| 만약 귀하 또는 귀하가 돕는 사람이 잘문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 회원 카드 뒷면에 있는고객 서비스<br>번호로 전화하십시오. 회원이 아니시거나 카드가 없으시면 855-710-6984 오로 전화주십시오.   |
| ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກ່າລັງ ໃຫ້ການຊ່ວຍເຫຼືອມີຄຳຖາມ. ທ່ານມີສິດຂໍເອົາການຊ່ວຍເຫຼືອ ແລະ ຂໍມູນເປັນນພາສາຂອງທ່ານໄດ້ໂດຍບໍ່ມີຄ່າ<br>ໃຊ້ຈ່າຍ. ເພື່ອລົມກັບນາຍແປພາສາ, ໃຫ້ໂທຫາເບີຜ່າຍບໍລິການລູກຄ້າທີ່ມີຢູ່ດ້ານຫຼັງບັດສະມາຊິກຂອງທ່ານ. ຖ້າທ່ານບໍ່ແມ່ນສະມາຊິກ, ຫຼື ບໍ່ມີບັດ, ໃຫ້ໂທຫາເບີ 855-710-6984.   |
| T'áá ni, éi doodago la'da bíká anánílwo'igií, na'idílkidgo, ts'idá bee ná ahóóti'i' t'áá níík'e níká a'doolwol. Ata' halne'í bich'i' hadeesdzih nínízingo éi kwe'é da'iniishgi áká anídaalwo'igií bich'i' hodíilnih, bee nééhózinii bine'déé bikáá'. Kojí atah naaltsoos ná hadít'éégóó éi doodago bee nééhózinigií ádingo koji' hodíilnih 855-710-6984.                                       |
| اگر شما، با کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور ر ایگان کمک و اطلاعات دریافت نمایید. حیث گفتگو با یک مترجم شناهی، 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 898-710-898 تماس حاصل نمایید.  |
| 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.  |
| 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.                     |
| หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีข้อสงสัยใด ๆ คุณมีสิทธิที่จะได้รับความช่วยเหลือ และข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย<br>พูดคุยกับล่ามโดยติดต่อฝ่ายบริการลูกด้าที่หมายเลขตามที่ระบุด้านหลังบัตรสมาชิก หากไม่ใช่สมาชิกหรือไม่มีบัดร กรุณาติดต่อที่หมายเลข 855-710-6984  |
| گر آپ کو، یا کسی ایسے فر د کو جس کی آپ مدد کر رہے ہیں، کوئی سوال در پیش 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<br>کار ڈ کی بشت ہر درج ہے۔ اگر آب ممبر نہیں ہیں، با آپ کے باس گار ڈ نہیں ہے تو، 858-710-858 ہر کال کر ہر ہ   |
| Nếu quý vị hoặc người mà quý vị giúp đỡ có bất kỷ 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 thể, gọi số 855-710-6984.   |
|  |

## Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator

300 E. Randolph St.

35th Floor

Chicago, Illinois 60601

Phone:

855-664-7270 (voicemail)

TTY/TDD:

855-661-6965 855-661-6960

Fax: 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

200 Independence Avenue SW

Room 509F, HHH Building 1019 Washington, DC 20201

Phone:

800-368-1019

800-537-7697 TTY/TDD:

Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html