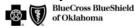
Coverage for: Individual/Family | Plan Type: PPO



: Blue Preferred Gold PPO<sup>™</sup> 205

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, visit <a href="http://www.bcbsok.com/policy-forms/2018/OK0320088-01.pdf">http://www.bcbsok.com/policy-forms/2018/OK0320088-01.pdf</a> or by calling 1-866-520-2507. 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.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf">https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf</a> or call 1-855-756-4448 to request a copy.

luan autout Ouastians	Anamara	Why This Matters
Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: \$200 Individual/\$600 Family. Out-of-Network: \$600 Individual/\$1,800 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. <u>Deductibles</u> don't apply to in-network <u>preventive care</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</u> <u>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>https://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-pocket</u> <u>limit</u> for this <u>plan</u> ?	Network: \$7,350 Individual/\$14,700 Family. Out-of-Network: Unlimited Individual/Unlimited 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-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	For a list of <u>network providers</u> please call <b>1-866-520-2507</b> or see <b>www.bcbsok.com</b> .	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 <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		What You	ı Will Pay	Limitations Everytians (Caboulumenter)
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	40% coinsurance	50% coinsurance	Virtual visits may be available. *Please refer to your policy for more details.
	Specialist visit	40% coinsurance	50% coinsurance	No <u>referral</u> Required.
If you visit a health care provider's office or clinic	Preventive care/screening/ immunization	No Charge; <u>deductible</u> does not apply	30% coinsurance	Annual mammography screening and childhood immunizations are covered at 100% of the allowable amount Out-of-Network. 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	<u>Diagnostic test</u> (x-ray, blood work)	Hospital – 40% coinsurance Non-Hospital - 20% coinsurance	50% <u>coinsurance</u>	None.
If you have a test	Imaging (CT/PET scans, MRIs)	Hospital – 40% <u>coinsurance</u> Non-Hospital - 20% <u>coinsurance</u>	50% coinsurance	<u>Preauthorization</u> is required for some services. *See benefit booklet for more details.
If you need drugs to treat your illness or condition More information about prescription drug	Preferred generic drugs	Retail Preferred - No Charge Non-Preferred \$10/prescription Mail - No Charge deductible does not apply	Retail – \$10/prescription deductible does not apply	Limited to a 30-day supply at retail (or a 90-day supply at a network of select retail pharmacies). Up to a 90-day supply at mail order. Specialty drugs limited to a 30-day supply. Payment of the difference between the cost of a brand name drug and a generic
nttps://www.myprime. com/content/dam/ prime/memberportal/ forms/AuthorForms/ HIM/2018/OK_6T_EX. pdf	Non-preferred generic drugs	Retail Preferred-\$10/prescription Non-Preferred \$20/prescription Mail - \$30/prescription deductible does not apply		may also be required if a generic drug is available. All Out-of-Network prescriptions are subject to a 50% additional charge after the applicable copay/coinsurance. Additional charge will not apply to any deductible or out-of-pocket amounts.

<sup>\*</sup>For more information about limitations and exceptions, see the <u>plan</u> or policy document at <a href="http://www.bcbsok.com/policy-forms/2018/0K0320088-01.">http://www.bcbsok.com/policy-forms/2018/0K0320088-01.</a> pdf.

Common	What You Will Pay		Limitations, Exceptions, & Other Important	
Medical Event	Services You May Need	will pay the least)	Out-of-Network Provider (You will pay the most)	Information
	Preferred brand drugs	Preferred-20% <a href="mailto:coinsurance">coinsurance</a> / Non-Preferred-25% <a href="mailto:coinsurance">coinsurance</a>	Retail - 25% <u>coinsurance</u>	
	Non-preferred brand drugs	Retail Preferred-35% <u>coinsurance</u> / Non-Preferred-40% <u>coinsurance</u>	Retail - 40% <u>coinsurance</u>	
	Preferred specialty drugs	Retail - 45% <u>coinsurance</u>	Retail - 45% <u>coinsurance</u>	
	Non-Preferred specialty drugs	Retail - 50% <u>coinsurance</u>	Retail - 50% <u>coinsurance</u>	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Hospital – \$300/visit plus 40% <u>coinsurance</u> Non-Hospital - \$300/visit plus 20% <u>coinsurance</u>	coinsurance	Copayment is charged in addition to the overall deductible. Elective abortion is not covered. \$500 penalty for failure to preauthorize Out-of-Network.
	Physician/surgeon fees	40% coinsurance	50% coinsurance	preautiforize out-of-Network.
If way was discussed in the	Emergency room care	\$950/visit plus 40% coinsurance	\$950/visit plus 40% coinsurance	<u>Copayment</u> is charged in addition to the overall <u>deductible</u> and is waived if admitted.
If you need immediate medical attention	Emergency medical transportation	40% coinsurance	40% coinsurance	None.
	Urgent care	40% coinsurance	50% coinsurance	Copayment may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$400/visit plus 40% coinsurance	\$1,500/visit plus 50% coinsurance	<u>Copayment</u> is charged in addition to the overall <u>deductible</u> . \$500 penalty for failure to
Stay	Physician/surgeon fees	40% coinsurance	50% coinsurance	preauthorize.
	Outpatient services	40% coinsurance	50% <u>coinsurance</u>	<u>Preauthorization</u> required. \$500 penalty for
If you need mental health, behavioral health, or substance abuse services	Inpatient services	\$400/visit plus 40% coinsurance	\$1,500/visit plus 50% coinsurance	failure to preauthorize. Virtual visits may be available for Outpatient services, *please refer to your policy for more details. Inpatient: <a href="mailto:copayment">copayment</a> is charged in addition to the overall <a href="mailto:deductible">deductible</a> .
If you are pregnant	Office visits	40% <u>coinsurance</u>	50% <u>coinsurance</u>	Cost sharing does not apply to certain preventive services. Depending on the type of

<sup>\*</sup>For more information about limitations and exceptions, see the <u>plan</u> or policy document at <a href="http://www.bcbsok.com/policy-forms/2018/0K0320088-01.">http://www.bcbsok.com/policy-forms/2018/0K0320088-01.</a>
<a href="pdf">pdf</a>.

Common		What You Will Pay		Limitations, Exceptions, & Other Important
Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Information
	Childbirth/delivery professional services	40% coinsurance	50% coinsurance	services, <u>coinsurance</u> may apply. Maternity care may include tests and services described
	Childbirth/delivery facility services	\$400/visit plus 40% coinsurance	\$1,500/visit plus 50% coinsurance	elsewhere in the SBC (i.e. ultrasound). Inpatient copayment is charged in addition to the overall deductible.
	Home health care	40% coinsurance	50% coinsurance	30 visit maximum per benefit period. \$500 penalty for failure to preauthorize.
	Rehabilitation services	40% coinsurance	50% coinsurance	Outpatient: Combined 25 visit limit per benefit
If you need help recovering or have	Habilitation services	40% coinsurance	50% coinsurance	period for physical, speech, occupational therapy and muscle manipulation services. Inpatient: 30 day maximum per benefit period. Preauthorization required; \$500 penalty if not preauthorized at least one business day prior to admission.
other special health needs	Skilled nursing care	40% coinsurance	50% coinsurance	30 visit maximum per benefit period. \$500 penalty for failure to preauthorize.
	Durable medical equipment	40% coinsurance	50% coinsurance	Medically necessary rental or purchase at the plan's discretion.
	Hospice services	40% coinsurance	50% <u>coinsurance</u>	Inpatient <u>copayment</u> may apply. <u>Preauthorization</u> required; \$500 penalty if not preauthorized at least one business day prior to admission.
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	One visit per year. *See benefit booklet for network details.
	Children's glasses	No Charge	Not Covered	One pair of glasses per year. *See benefit booklet for <u>network</u> details.
	Children's dental check-up	Not Covered	Not Covered	None

<sup>\*</sup>For more information about limitations and exceptions, see the <u>plan</u> or policy document at <a href="http://www.bcbsok.com/policy-forms/2018/OK0320088-01.">http://www.bcbsok.com/policy-forms/2018/OK0320088-01.</a>
<a href="pdf">pdf</a>.

#### **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.)

- Abortions (Unless the life of the mother is endangered)

Routine eye care (Adult)

Acupuncture

 Dental Care (Adult ) Infertility treatment

Routine foot care (Except for diabetic subscribers)

Long-term care

Weight loss programs

- Bariatric surgery (For weight loss purposes)
- Cosmetic surgery (With exception of accidental injury repair and some instances for physiological functioning improvement of a malformed body member)
- Non-emergency care when traveling outside the U.S.

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

• Chiropractic care (Limited to 25 visits per calendar • Hearing aids (Limited to one for each ear every • Private-duty nursing (Limited to 85 visits per year) 48 months) year.)

#### **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 1-866-520-2507. You may also contact your state insurance department at 1-405-521-2991. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a <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 www.bcbsok.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. Contact the Oklahoma Department of Insurance at 1-405-521-2991 or www.oid.ok.gov.

Additionally, a consumer assistance program can help you file your appeal. Contact the Oklahoma Department of Insurance's Consumer Health Assistance Program at 1-800-522-0071 or visit <a href="https://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/ok.html">https://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/ok.html</a>.

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

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

### **Language Access Services:**

Spanish (Español): Spanish (Español): Para obtener asistencia en Español, llame al 1-866-520-2507.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-520-2507.

Chinese (中文): 如果需要中文的帮助,请拨打这个号码 1-866-520-2507.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-520-2507.

#### **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 <u>excluded services</u> 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 in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$200
Specialist coinsurance	40%
Hospital (facility) both	\$400 + 40%
Other <u>coinsurance</u>	40%

#### This EXAMPLE event includes services like:

Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost	\$12,800	
In this example, Peg would pay:		
Cost Sharing		
Deductibles	\$200	
Copayments	\$400	
Coinsurance	\$4,600	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$5,260	

# 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>	\$200
Specialist coinsurance	40%
Hospital (facility) both	\$400 + 40%
Other <u>coinsurance</u>	40%

#### This EXAMPLE event includes services like:

Primary care physician office visits (including disease education)
Diagnostic tests (blood work)
Prescription drugs
Durable medical equipment (alucose meter)

Total Evennela Cost

i otal Example Cost	\$7,400
In this example, Joe would pay:	
Cost Sharing	
Deductibles	\$200
Copayments	\$0
Coinsurance	\$1,800
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$2,060

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

■ The <u>plan's</u> overall <u>deductible</u>	\$200
Specialist coinsurance	40%
■ Hospital (facility) both	\$400 + 40%
Other coinsurance	40%

#### This EXAMPLE event includes services like:

Total Evennle Cost

Ċ7 400

Emergency room care (including medical supplies)
Diagnostic test (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

\$200
\$0
\$700
\$0
\$900

¢1 000

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 أسنلة، 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 6984-710-855.
မွနျမာ Burmese	သင် သို့မဟုတ် သင်ကူညီပေးနေသူတဦးမှ မေးမြန်းလိုသည့် မေးခွန်းများရှိပါက သင့် ဘာသာစကားဖြင့် အကူအညီနှင့် အချက်အလက်များကို အခမဲ့ဖြင့်ရယူနိုင်သည့်အခွင့်အရေးရှိပါသ ည်။ ဘာသာစကား ပြန်ဆိုသူနှင့် စကားပြောရန် သင့် အဖွဲ့ ဂင်ကဒ်၏ နောက်ကျောဖက်ပေါ် ရှိ သုံးစွဲသူ ဂန်ဆောင်မှု ဖုန်းနံပါတ်သို့ ခေါ်ဆိုပါ။ အကယ်၍ သင်သည် အဖွဲ့ ဂင်တစ်ဦး မဟုတ်ခဲ့ပါက သို့မဟုတ် ကဒ် မရှိပါက 855- 710-6984 သို့ ခေါ်ဆိုပါ။
GWY Cherokee	h.JZ, D& YGT ፀ .J.ൽSP:ൽEY, &%ሮሮኤൽ\$, h.J G.J/ ፀላንሃ RGP:ൽS\L/J D& RGZ4.// С'U G\D\h.J.ൽ.// EWOY D4\V*\V*. ፀላንሃZ D.ମP.J.ൽሃ G\&\L&Z\P.J.T, ወ\p.J.b\Wo`b ፀላንሃፀT O'hG:ላዕሃ DፀኒൽSP:ላዕሃ ፀላንሃ PPT GVP & J.O° DI.h.ሴላን SA.ህ\T J4ላንJ/PӨ h\PRO .&Y, D& DI.h.ሴላን hGO:Ө .&Y, ወላንb\Wo`\$ D\J/h 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請致電印在您的會員卡背面的客戶服務電話號碼。如果您不是會員, 或沒有 會員卡, 請致電 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, composez le numéro du service client indiqué au verso de votre carte de membre. Si vous n'êtes pas membre ou si vous n'avez pas de carte, veuillez composer le 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Kundenservicenummer auf der Rückseite Ihrer Mitgliedskarte an. Falls Sie kein Mitglied sind oder keine Mitgliedskarte besitzen, rufen Sie bitte 855-710-6984 an.
Hmoob Hmong	Yog koj, los yog tej tus neeg uas koj pab ntawd muaj lus nug txog, koj muaj cai hais kom lawv pab muab cov ntaub ntawv sau ua koj hom lus pub dawb rau koj. Xav tham nrog ib tug kws txhais lus, hu rau tus nab npawb xovtooj pab cuam neeg qhua uas nyob sab tom qab ntawm koj daim npav tswv cuab. Yog koj tsis yog ib tug neeg tswv cuab, los yog koj tsis muaj npav, hu rau 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 회원 카드 뒷면에 있는고객 서비스 번호로 전화하십시오. 회원이 아니시거나 카드가 없으시면 855-710-6984 으로 전화주십시오.
ພາສາລາວ Laotian	ຖ້າທ່ານ ຫຼື ຄົນທີທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອມີຄຳຖາມ, ທ່ານມີສິດຂໍເອົາການຊ່ວຍເຫຼືອ ແລະ ຂໍມູນເປັນນພາສາຂອງທ່ານໄດ້ໂດຍບໍມີຄ່າ ໃຊ້ຈ່າຍ. ເພື່ອລົມກັບນາຍແປພາສາ, ໃຫ້ໂທຫາເບີຜ່າຍບໍລິການລູກຄ້າທີ່ມີຢູ່ດ້ານຫຼັງບັດສະມາຊິກຂອງທ່ານ. ຖ້າທ່ານບໍ່ແມ່ນສະມາຊິກ, ຫຼື ບໍ່ມີບັດ, ໃຫ້ໂທຫາເບີ 855-710-6984.
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'i' hadeesdzih nínízingo éí kwe'é da'íníishgi áká anídaalwo'ígíí bich'i' hodíílnih, bee nééhózinii bine'dęę' bikáá'. Kojí atah naaltsoos ná hadít'éégóó éí doodago bee nééhózinígíí ádingo koji' hodíílnih 855-710-6984.
فارس <i>ی</i> Persian	اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با خدمات مشتری به شماره ای که در پشت کارت عضویت ندارید، با شماره 884ه-710-585 تماس حاصل نمایید.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete comuníquese con el número del Servicio al Cliente que figura en el reverso de su tarjeta de miembro. Si usted no es miembro o no posee una tarjeta, llame al 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa numero ng serbisyo para sa kustomer sa likod ng iyong kard ng miyembro. Kung ikaw ay hindi isang miyembro, o kaya ay walang kard, tumawag sa 855-710-6984.
<b>ไทย</b> Thai	หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีข้อสงสัยใด ๆ คุณมีสิทธิที่จะได้รับความช่วยเหลือ และข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่ามโดยติดต่อฝ่ายบริการลูกค้าที่หมายเลขตามที่ระบุด้านหลังบัตรสมาชิก หากไม่ใช่สมาชิกหรือไม่มีบัตร กรุณาติดต่อที่หมายเลข 855-710-6984
ار دو Urdu	گر 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، 8984-710-855 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.



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