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, visit

https://www.bcbsok.com/policy-forms/2019/GPSH45BVPIOKO.pdf or by calling 1-866-520-2507. For general definitions of common terms, such as <u>allowed</u> amount, <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 <u>https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf</u> or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<u>Network</u> : \$1,200 Individual/\$3,600 Family Out-of-Network: \$3,600 Individual/\$10,800 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 <u>deductible</u> ?	Yes. In-Network Preventive Health, services with a copay, and some <u>prescription drugs</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</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 <u>deductibles</u> 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> ?	<u>Network</u> : \$7,900 Individual/\$15,800 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?	<u>Premiums, balance-billed</u> charges, and 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> .
Will you pay less if you use a <u>network provider</u> ?	Yes. For a list of <u>network</u> <u>providers</u> please call 1-866-520-2507 or see <u>www.</u> <u>bcbsok.com</u> .	This <u>plan</u> uses a <u>provider</u> <u>network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's</u> <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 <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance</u> <u>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 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	
		Primary care visit to treat an injury or illness	\$25/visit; <u>deductible</u> does not apply	30% coinsurance	Virtual Visits are available. See your benefit booklet* for details.
If you visit a hea	lth care	<u>Specialist</u> visit	25% coinsurance	30% <u>coinsurance</u>	None
<u>provider's</u> office or clinic	Preventive care/screening/ immunization	No Charge; <u>deductible</u> does not apply	30% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.	
lf you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Freestanding Facility: 15% <u>coinsurance</u> Hospital: 25% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required; see your	
	Imaging (CT/PET scans, MRIs)	Freestanding Facility: 15% <u>coinsurance</u> Hospital: 25% <u>coinsurance</u>	30% <u>coinsurance</u>	benefit booklet* for details.	

Common		What You	ı 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
	Preferred generic drugs	Retail - Preferred - \$5/prescription Non-Preferred - \$10/prescription Mail - \$15/prescription; <u>deductible</u> does not apply	Retail - \$10/prescription; <u>deductible</u> does not apply	
If you need drugs to treat your illness or condition More information about prescription drug	Non-preferred generic drugs	Retail - Preferred - \$10/prescription Non-Preferred - \$20/prescription Mail - \$30/prescription; <u>deductible</u> does not apply	Retail - \$20/prescription; <u>deductible</u> does not apply	Limited to a 30-day supply at retail (or a 90-day supply at a <u>network</u> of select retail pharmacies). Up to a 90-day supply at mail order. <u>Specialty drugs</u> limited to a 30-day supply. Payment of the difference between
coverage is available at https://www.myprime. com/content/dam/ prime/memberportal/ forms/AuthorForms/ HIM/2019/2019 OK 6T	Preferred brand drugs	Retail - Preferred - \$50/prescription Non-Preferred - \$70/prescription Mail - \$150/prescription; <u>deductible</u> does not apply	Retail - \$70/prescription; <u>deductible</u> does not apply	the cost of a brand name drug and a generic 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/ <u>coinsurance</u> . Additional charge will not apply to any <u>deductible</u> or
HIM.pdf	Non-preferred brand drugs	Retail - Preferred - \$100/prescription Non-Preferred - \$120/prescription Mail - \$300/prescription; <u>deductible</u> does not apply	Retail - \$120/prescription; <u>deductible</u> does not apply	out-of-pocket amounts.
	Preferred <u>specialty drugs</u>	45% coinsurance	45% <u>coinsurance</u>	
	Non-Preferred <u>specialty drugs</u>	50% coinsurance	50% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Freestanding Facility: 15% <u>coinsurance</u> Hospital: 25% <u>coinsurance</u>	coinsurance	<u>Preauthorization</u> may be required. For Outpatient Infusion Therapy, see your benefit booklet* for details.
	Physician/surgeon fees	25% <u>coinsurance</u>	30% <u>coinsurance</u>	

*For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>https://www.bcbsok.com/policy-forms/2019/GPSH45BVPI0K0.pdf</u>.

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	
	Emergency room care	\$950/visit plus 25% <u>coinsurance</u>	\$950/visit plus 25% <u>coinsurance</u>	None	
If you need immediate medical attention	Emergency medical transportation	25% <u>coinsurance</u>	25% <u>coinsurance</u>	<u>Preauthorization</u> may be required for non-emergency transportation; see your benefit booklet* for details.	
	<u>Urgent care</u>	25% coinsurance	30% coinsurance	Office visit <u>copayment</u> may apply instead of <u>coinsurance</u> .	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$400/visit plus 25% coinsurance	\$1,500/visit plus 30% coinsurance	<u>Preauthorization</u> required. <u>Preauthorization</u> penalty: \$500. See your benefit booklet* for	
	Physician/surgeon fees	25% coinsurance	30% coinsurance	details.	
If you need mental	Outpatient services	25% coinsurance	30% coinsurance	Outpatient: <u>Preauthorization</u> may be required; see your benefit booklet* for details. Inpatient: <u>Preauthorization</u> required.	
health, behavioral health, or substance abuse services	Inpatient services	\$400/visit plus 25% coinsurance	\$1,500/visit plus 30% coinsurance		
	Office visits	Primary Care: \$25 <u>Specialist</u> : 25% <u>coinsurance</u>	30% <u>coinsurance</u>	Copay applies to first prenatal visit (per pregnancy). <u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the	
If you are pregnant	Childbirth/delivery professional services	25% <u>coinsurance</u>	30% <u>coinsurance</u>	type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services	
	Childbirth/delivery facility services	\$400/visit plus 25% coinsurance	\$1,500/visit plus 30% coinsurance	described elsewhere in the SBC (i.e. ultrasound).	

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
	<u>Home health care</u>	25% coinsurance	30% <u>coinsurance</u>	30 visits/year. <u>Preauthorization</u> may be required.
	Rehabilitation services	25% coinsurance	30% <u>coinsurance</u>	Preauthorization may be required. Outpatient:
If you need help recovering or have other special health needs	Habilitation services	25% <u>coinsurance</u>	30% <u>coinsurance</u>	Combined 25 visit limit per benefit period for physical, speech, occupational therapy and muscle manipulation. Inpatient: 30 day maximum per benefit period. <u>Preauthorization</u> penalty: \$500.
	Skilled nursing care	25% <u>coinsurance</u>	30% <u>coinsurance</u>	30 days/year. <u>Preauthorization</u> may be required. Inpatient <u>Preauthorization</u> penalty: \$500.
	Durable medical equipment	25% <u>coinsurance</u>	30% <u>coinsurance</u>	Preauthorization may be required.
	Hospice services	25% coinsurance	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required. Inpatient <u>Preauthorization</u> penalty: \$500.
If your child needs dental or eye care	Children's eye exam	No Charge; <u>deductible</u> does not apply	Not Covered	One visit per year. See your benefit booklet* for details.
	Children's glasses	No Charge; <u>deductible</u> does not apply	Not Covered	One pair of glasses per year. See your benefit booklet* for details.
	Children's dental check-up	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.)

 Abortion (Unless the life of the mother is • Dental Care (Adult and Child) • Routine eye care (Adult) • Infertility treatment Routine foot care (Except for diabetic subscribers) endangered) Acupuncture • Long-term care • Weight loss programs Bariatric surgery (For weight loss purposes) • Non-emergency care when traveling outside the · Cosmetic surgery (With exception of accidental U.S. injury repair and some instances for physiological functioning improvement of a malformed body member)

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

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 1-800-522-0071. 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 <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 explanation 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>. Contact the Oklahoma Department of Insurance at 1-405-521-2991 or <u>www.oid.ok.gov</u>.

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 <u>https://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/ok.html</u>.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have <u>Minimum Essential Coverage</u> 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): 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.

———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 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)		Managing Joe's type 2 Diab (a year of routine in-network ca well-controlled condition	
 The <u>plan's</u> overall <u>deductible</u> <u>Specialist coinsurance</u> Hospital (facility) copay/coins. 	\$1,200 25% \$400 + 25%	 The <u>plan's</u> overall <u>deductible</u> <u>Specialist coinsurance</u> Hospital (facility) copay/coins. 	
 Other <u>coinsurance</u> 	25%	 Other <u>coinsurance</u> 	
This EXAMPLE event includes servi	ices like:	This EXAMPLE event includes servic	

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	

oost onanng		
Deductibles	\$1,200	
Copayments	\$400	
Coinsurance	\$2,700	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$4,360	

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>	\$1,200
Specialist coinsurance	25%
Hospital (facility) copay/coins.	\$400 + 25%
Other coinsurance	25%

vices like: nis example event includes ser

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

Total Example Cost	\$7,400
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In this example, Joe would pay:

Cost Sharing				
Deductibles	\$1,200			
Copayments	\$1,000			
Coinsurance	\$200			
What isn't covered				
Limits or exclusions	\$60			
The total Joe would pay is	\$2,460			

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

The <u>plan's</u> overall <u>deductible</u>	\$1,200
Specialist coinsurance	25%
Hospital (facility) copay/coins.	\$400 + 25%
Other <u>coinsurance</u>	25%

This EXAMPLE event includes services like:

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

Total Example Cost	\$1,900
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,200
Copayments	\$300
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,600



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	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
Arabic	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 ရှ သုံးစွဲသူ ဂန်ဆောင်မှု ဖုန်းနံပါတ်သို့ ခေါ်ဆိုပါ။ အကယ်၍ သင်သည် အဖွဲ့ ဂင်တစ်ဦး မဟုတ်ခဲ့ပါက သို့မဟုတ် ကဒ် မရှိပါက 855- 710-6984 သို့ ခေါ်ဆိုပါ။
GWY	ℎ <i>℈</i> ℤ, ⅅℰ <i>℣</i> ₢₸ Ѳ <i>℈ⅆ</i> ⅁ℇℙⅆℇℒ, ⅆ℈ℰⅆ℆ⅆⅆ℁, ℎℬ Gⅆ ℗ⅆ℧ℒ℞ℂℙⅆℇ℄⅃ ⅅℰ℞ℂℤ℄⅃ ℂℍ ℧℗ℎℬⅆℋℇѠ℗ℒⅅ℄⅌℁ഀ. ℗ⅆ℧ℤ ⅅℳℙ⅄ⅆ℧ℒ℧ℳℙ⅄ⅆ℧ℒ℧ℳℙℴⅆ℧ℋ
Cherokee	ⅅϴႱⅆℨℙⅆ℧ℒ℗ⅆ℧ℒℙℙℾ ⅆℋℙ ℰ⅄ℰ ⅅℾℎℎⅆℳ Տ⅄ⅆ⅌⅂ℾℳⅆⅆℳℳℙ℗ℎℙ℞℗ℬ⅄, ⅅℰ ⅅℾℎℎⅆℳℎℂ℗℗ℬℒ, ℗ⅆ℧ℍⅆ℅ℌ ⅅⅆℎ 855-710-6984.
繁體中文	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
Chinese	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	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
Korean	번호로 전화하십시오. 회원이 아니시거나 카드가 없으시면 855-710-6984 으로 전화주십시오.
ພາສາລາວ	ຖ້າທ່ານ ຫຼື ຄົນທີທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອມີຄຳຖາມ, ທ່ານມີສິດຂໍເອົາການຊ່ວຍເຫຼືອ ແລະ ຂໍມູນເປັນນພາສາຂອງທ່ານໄດ້ໂດຍບໍມີຄ່າ
Laotian	ໃຊ້ຈ່າຍ. ເພື່ອລົມກັບນາຍແປພາສາ, ໃຫ້ໂທຫາເບີຝ່າຍບໍລິການລູກຄ້າທີ່ມີຢູ່ດ້ານຫຼັງບັດສະມາຊິກຂອງທ່ານ. 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'dęé' bikáá'. Kojí atah naaltsoos ná hadít'éégóó éí doodago bee nééhózinígíí ádingo koji' hodíílnih 855-710-6984.
فارسی	اگر شما، یا کسی که شما به او کمک مي کنيد، سؤالی داشته باشيد، حق اين را داريد که به زبان خود، به طور ر ايگان کمک و اطلاعات دريافت نماييد. جهت گفتگو با يک مترجم شفاهی، با خدمات مشتری به شماره ای که در پشت کارت عضويت شما
Persian	در ج شده است تماس بگيريد. اگر عضو نيستيد، يا کارت عضويت نداريد، با شماره 6984-710-855 تماس حاصل نماييد.
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.
ไทย	หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีข้อสงสัยใด ๆ คุณมีสิทธิที่จะได้รับความช่วยเหลือ และข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย
Thai	พูดคุยกับล่ามโดยติดต่อฝ่ายบริการลูกค้าที่หมายเลขตามที่ระบุด้านหลังบัตรสมาชิก หากไม่ใช่สมาชิกหรือไม่มีบัตร กรุณาติดต่อที่หมายเลข 855-710-6984
اردو	گر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کر رہے 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
Urdu	کارڈ کی پشت پر درج ہے۔ اگر آپ ممبر نہیں ہیں، یا آپ کے پاس کارڈ نہیں ہے تو، 6984-710-855 پر کال کریں۔
Tiếng Việt	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
Vietnamese	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 855-664-7270 (voicemail) Phone: 300 E. Randolph St. TTY/TDD: 855-661-6965 35th Floor 855-661-6960 Fax: 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 800-368-1019 Phone: 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 Washington, DC 20201