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 https://www.bcbsok.com/member/policy-forms/2019 or by calling 1-800-942-5837. 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 https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $3,750 Individual/$11,250 Family Out-of-Network: $7,500 Individual/$22,500 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-Network Preventive Health, services with a copay, and prescription drugs are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: $7,000 Blue Preferred, $7,300 Blue Choice Individual; $14,000 Blue Preferred, $14,600 Blue Choice Family Out-of-Network: Unlimited Individual, Unlimited Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. For a list of network providers please call 1-800-942-5837 or see www.bcbsok.com.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Blue Preferred Provider (You will pay the least)	Blue Choice Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40/visit; deductible does not apply	$40/visit; deductible does not apply	30% coinsurance	Virtual Visits are available. See your benefit booklet* for details.
	Specialist visit	$60/visit; deductible does not apply	$60/visit; deductible does not apply	30% coinsurance	None
	Preventive care/screening/ immunization	No Charge; deductible does not apply	No Charge; deductible does not apply	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	30% coinsurance	50% coinsurance	Preauthorization may be required; see your benefit booklet* for details.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	50% coinsurance	

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Blue Preferred Provider (You will pay the least)	Blue Choice Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.myprime.com/content/dam/prime/memberportal/forms/AuthorForms/HIM/2019/2019_OK_6T_HIM.pdf	Preferred generic drugs	Retail - Preferred No Charge Non-Preferred - $10/prescription Mail - No Charge; deductible does not apply	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 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.
	Non-preferred generic drugs	Retail - Preferred $10/prescription Non-Preferred - $20/prescription Mail - $30/prescription; deductible does not apply	Retail - Preferred $10/prescription Non-Preferred - $20/prescription Mail - $30/prescription; deductible does not apply	Retail - $20/prescription; deductible does not apply	
	Preferred brand drugs	Retail - Preferred $50/prescription Non-Preferred - $70/prescription Mail - $150/prescription; deductible does not apply	Retail - Preferred $50/prescription Non-Preferred - $70/prescription Mail - $150/prescription; deductible does not apply	Retail - $70/prescription; deductible does not apply	
	Non-preferred brand drugs	Retail - Preferred $100/prescription Non-Preferred - $120/prescription Mail - $300/prescription; deductible does not apply	Retail - Preferred $100/prescription Non-Preferred - $120/prescription Mail - $300/prescription; deductible does not apply	Retail - $120/prescription; deductible does not apply	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Blue Preferred Provider (You will pay the least)	Blue Choice Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	Preferred specialty drugs	$150/prescription; deductible does not apply	$150/prescription; deductible does not apply	$150/prescription; deductible does not apply	
	Non-Preferred specialty drugs	$250/prescription; deductible does not apply	$250/prescription; deductible does not apply	$250/prescription; deductible does not apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200/visit plus 20% coinsurance	$200/visit plus 30% coinsurance	$300/visit plus 50% coinsurance	Preauthorization may be required. For Outpatient Infusion Therapy, see your benefit booklet* for details.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	$500/visit plus 20% coinsurance	$500/visit plus 20% coinsurance	$500/visit plus 20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	20% coinsurance	Preauthorization may be required for non-emergency transportation; see your benefit booklet* for details.
	Urgent care	20% coinsurance	30% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$300/visit plus 20% coinsurance	$300/visit plus 30% coinsurance	$400/visit plus 50% coinsurance	Preauthorization required. Preauthorization penalty: $500. See your benefit booklet* for details.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40/office visits or 20% coinsurance for other outpatient services	$40/office visits or 30% coinsurance for other outpatient services	30% coinsurance for office visits or 50% coinsurance for other outpatient services	Outpatient: Preauthorization may be required; see your benefit booklet* for details. Inpatient: Preauthorization required.
	Inpatient services	$300/visit plus 20% coinsurance	$300/visit plus 30% coinsurance	$400/visit plus 50% coinsurance	

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Blue Preferred Provider (You will pay the least)	Blue Choice Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	Primary Care: $40 Specialist: $60; deductible does not apply	Primary Care: $40 Specialist: $60; deductible does not apply	50% coinsurance	Copay applies to first prenatal visit (per pregnancy). Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	$300/visit plus 20% coinsurance	$300/visit plus 30% coinsurance	$400/visit plus 50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	50% coinsurance	30 visits/year. Preauthorization may be required.
	Rehabilitation services	20% coinsurance	30% coinsurance	50% coinsurance	Preauthorization may be required. Outpatient: Combined 25 visit limit per benefit period for physical, speech, occupational therapy and muscle manipulation. Inpatient: 30 day maximum per benefit period. Preauthorization penalty: $500.
	Habilitation services	20% coinsurance	30% coinsurance	50% coinsurance	
	Skilled nursing care	20% coinsurance	30% coinsurance	50% coinsurance	30 days/year. Preauthorization may be required. Inpatient Preauthorization penalty: $500.
	Durable medical equipment	20% coinsurance	30% coinsurance	50% coinsurance	Preauthorization may be required.
	Hospice services	20% coinsurance	30% coinsurance	50% coinsurance	Preauthorization may be required. Inpatient Preauthorization penalty: $500.
If your child needs dental or eye care	Children's eye exam	No Charge; deductible does not apply	No Charge; deductible does not apply	Not Covered	One visit per year. See your benefit booklet* for details.
	Children's glasses	No Charge; deductible does not apply	No Charge; deductible does not apply	Not Covered	One pair of glasses per year. See your benefit booklet* for details.
	Children's dental check-up	No Charge	No Charge	No Charge	None

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

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

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 year.)
- Hearing aids (Limited to one each ear every 48 months)
- Private-duty nursing (Limited to 85 visits per 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 1-800-942-5837, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 claim, appeal, or a grievance for any reason to your plan. 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.

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): 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 plan might cover costs for a sample medical situation, see the next section.

About These Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$3,750
Specialist copayment	$60
Hospital (facility) copay/coins.	$300 + 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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,750
Copayments	$300
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,810**

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

The plan's overall deductible	$3,750
Specialist copayment	$60
Hospital (facility) copay/coins.	$300 + 20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$3,060**

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

The plan's overall deductible	$3,750
Specialist copayment	$60
Hospital (facility) copay/coins.	$300 + 20%
Other coinsurance	20%

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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,400
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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

BlueCross BlueShield of Oklahoma

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost.
To speak to an interpreter, call the customer service number on the back of your member card. If you are not a member, or don't have a card, call 855-710-6984.

العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث إلى مترجم فوري، اتصل على رقم خدمة العملاء المذكور على ظهر بطاقة عضويتك. فإن لم تكن عضوًا، أو كنت لا تملك بطاقة، فاتصل على 855-710-6984.
မြန်မာ Burmese	သင် သို့မဟုတ် သင်ကူညီပေးနေသူတဦးမှ မေးမြန်းလိုသည့် မေးခွန်းများရှိပါက သင့် ဘာသာစကားဖြင့် အကူအညီနှင့် အချက်အလက်များကို အခမဲ့ဖြင့်ရယူနိုင်သည့်အခွင့်အရေးရှိပါသ ည်။ ဘာသာစကားပြန်ဆိုသူနှင့် စကားပြောရန် သင့် အဖွဲ့ဝင်ကဒ်၏ နောက်ကျောဖက်ပေါ်ရှိ သုံးစွဲသူ ဝန်ဆောင်မှု ဖုန်းနံပါတ်သို့ ခေါ်ဆိုပါ။ အကယ်၍ သင်သည် အဖွဲ့ဝင်တစ်ဦး မဟုတ်ခဲ့ပါက သို့မဟုတ် ကဒ် မရှိပါက 855-710-6984 သို့ ခေါ်ဆိုပါ။
ᏣᎳᎩ Cherokee	ᏂᎯᏃ, ᎠᎴ ᎩᏟᎢ Ꮎ ᎯᎠᏚᏢᎠᎬᎩ, ᏯᏛᏛᏜᎣᏍ, ᏂᎯ ᏩᏥ ᎾᏍᎩ ᎡᏩᏢᏍᏕᏗ ᎠᎴ ᎡᏩᏃᏗ ᏟᏌ ᏩᏅᏂᎯᏍᏗ ᎬᏬᏡᎩ ᎠᏎᏉᏉ. ᎾᏍᎩᏃ ᎠᏁᏢᏗᏍᎩ ᏩᏍᏓᏃᎮᏗᎢ, ᏫᏥᎯᏏᎳᏛᏏ ᎾᏍᎩᎾᎢ ᎤᏂᏩᏍᎩ ᎠᎾᏓᏍᏢᏍᎩ ᎾᏍᎩ ᎮᏢᎢ ᏩᏙᏢ ᏱᏗᏛ ᎠᏆᏂᏲᏍᏗ ᏚᎪᏪᎢ ᏗᏎᏍᏗ. ᏁᏢᎾ ᏂᏥᏒᎾ ᏱᎩ, ᎠᎴ ᎠᏆᏂᏲᏍᏗ ᏂᏩᏒᎾ ᏱᎩ, ᏫᏍᏓᏇᏛᏕ ᎠᏥᏂ 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 ຄົນທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອມີຄຳຖາມ, ທ່ານມີສິດຂໍເອົາການຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໄດ້ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອລົມກັບນາຍແປພາສາ, ໃຫ້ໂທຫາເບີຝ່າຍບໍລິການລູກຄ້າທີ່ມີຢູ່ດ້ານຫຼັງບັດສະມາຊິກຂອງທ່ານ. ຖ້າທ່ານບໍ່ແມ່ນສະມາຊິກ, ຫຼື ບໍ່ມີບັດ, ໃຫ້ໂທຫາເບີ 855-710-6984.
Diné Navajo	T'áá ni, éí doodago ła'da bíká ananílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł. Ata' halne'í bich'į' hadeesdzih nínízingo éí kwe'é da'íníishgi áká anídaalwo'ígíí bich'į' hodíílnih, bee néého̱zinii bine'dę́ę́' bikáá'. Kojí atah naaltsoos ná hadít'éégóó éí doodago bee néého̱zinígíí ádingo kojį' hodíílnih 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک مي 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 شما درج شده است تماس بگیرید. اگر عضو نیستید، یا کارت عضویت ندارید، با شماره 855-710-6984 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.
ไทย Thai	หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีข้อสงสัยใด ๆ คุณมีสิทธิที่จะได้รับความช่วยเหลือ และข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่ามโดยติดต่อฝ่ายบริการลูกค้าที่หมายเลขตามที่ระบุด้านหลังบัตรสมาชิก หากไม่ใช่สมาชิกหรือไม่มีบัตร กรุณาติดต่อที่หมายเลข 855-710-6984
اردو 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، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị hoặc người mà quý vị giúp đỡ có bất kỳ câu hỏi nào, quý vị có quyền được hỗ trợ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, gọi số dịch vụ khách hàng nằm ở phía sau thẻ hội viên của quý vị. Nếu quý vị không phải là hội viên hoặc không có thẻ, gọi số 855-710-6984.

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We provide free communication aids and services for anyone with a disability or who needs language assistance.
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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
Fax: 855-661-6960
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
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html