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, call 1-800-672-2567 or visit www.bcbsok.com/member/policy-forms. 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 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 <u>deductible</u> ?	<u>Network</u> : \$3,000 Individual / \$9,000 Family <u>Out-of-Network</u> : \$4,000 Individual / \$12,000 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. Services that charge a <u>copay</u> , <u>prescription</u> <u>drugs</u> , and certain <u>preventive care</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</u> <u>services</u> at <u>www.healthcare.gov/coverage/preventive-care-benefits/</u> .
Are there other <u>deductibles</u> for specific services?	Yes. Per occurrence: \$300 <u>Out-of-Network</u> inpatient admission. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	<u>Network</u> : \$6,350 Individual / \$13,000 Family <u>Out-of-Network</u> : \$7,500 Individual / \$15,000 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, balanced-billed charges, preauthorization penalties, and healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-</u> pocket limit.
Will you pay less if you use a <u>network provider</u> ?	Yes. See <u>www.bcbsok.com</u> or call 1-800-672-2567 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</u> 's <u>network</u> . You will pay the most if you use an <u>out-of-network</u> <u>provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider</u> 's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the specialist you choose without a referral.



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

Common		What You	u Will Pay	Limitations, Exceptions, & Other Important Information	
Medical Event	Services You May Need	Network Provider (you will pay the least)	Out-of-Network Provider (you will pay the most)		
	Primary care visit to treat an injury or illness	\$35 <u>copay</u> /visit; <u>deductible</u> does not apply	50% coinsurance	None	
16 · · · · · · · ·	<u>Specialist</u> visit	\$50 <u>copay</u> /visit; <u>deductible</u> does not apply	50% coinsurance	None	
If you visit a health care <u>provider</u> 's office or clinic	Preventive care/screening/immunization No Charge; <u>deductible</u> does not apply 30% coinsurance		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. Annual mammography screening and childhood immunizations are covered at No Charge <u>Out-of-Network</u> .		
If you have a test	Diagnostic test (x-ray, blood work)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None	
If you have a test	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	50% coinsurance	None	
If you need drugs to	Generic drugs	25% of allowed amount, \$25 min/\$50 max retail \$75 min/\$150 max mail; <u>deductible</u> does not apply	\$75 retail; <u>deductible</u> does not apply	Up to 30 day supply retail. Up to 90 day supply of maintenance drugs. Up to 90 day supply mail, Network only. Listed <u>copayments</u> are per prescription; Payment of the difference between the cost of a brand drug and a generic may	
treat your illness or condition More information about <u>prescription</u> <u>drug coverage</u> is available at <u>www.bcbsok.com/mem</u> <u>ber/prescriptiondrugs.h</u> tml	Preferred brand drugs	25% of allowed amount, \$25 min/\$50 max retail \$75 min/\$150 max mail; <u>deductible</u> does not apply	\$75 retail; <u>deductible</u> does not apply		
	Non-preferred brand drugs	50% of allowed amount, \$50 min/\$100 max retail \$150 min/\$300 max mail; <u>deductible</u> does not apply	\$125 retail; <u>deductible</u> does not apply	also be required if a generic drug is available. <u>Specialty drugs</u> must be obtained from Prime Specialty Pharmacy. Limited to 30 day supply. Mail order is not	
	Specialty drugs	50% of allowed amount, \$50 min/\$100 max; <u>deductible</u> does not apply	Not Covered	covered.	

* For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.bcbsok.com</u>

Common Medical Event	Services You May Need	Network Provider	ı Will Pay Out-of-Network Provider	Limitations, Exceptions, & Other Important Information
		(you will pay the least)	(you will pay the most)	
lf you have	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% <u>coinsurance</u>	Elective abortion is not covered.
outpatient surgery	Physician/surgeon fees	20% coinsurance	50% <u>coinsurance</u>	None
lf you need	Emergency room care	20% coinsurance	20% <u>coinsurance</u>	Additional \$100 <u>copay</u> per visit; waived if admitted.
immediate medical	Emergency medical transportation	20% coinsurance	20% <u>coinsurance</u>	None
attention	Urgent care	\$50 <u>copay</u> /visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	None
lf you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% <u>coinsurance</u>	Additional \$300 <u>deductible Out-of-Network</u> . <u>Preauthorization</u> required; \$500 penalty if not preauthorized <u>Out-of-Network</u> .
	Physician/surgeon fees	20% coinsurance	50% <u>coinsurance</u>	None
lf you need mental health, behavioral	Outpatient services	\$35 <u>copay</u> /office visit; <u>deductible</u> does not apply 20% <u>coinsurance</u> for other outpatient services	50% <u>coinsurance</u>	Preauthorization required for certain services.
health, or substance abuse services	Inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Additional \$300 <u>deductible Out-of-Network</u> . <u>Preauthorization</u> required; \$500 penalty if not preauthorized <u>Out-of-Network</u> .
lf you are pregnant	Office visits	20% coinsurance	50% <u>coinsurance</u>	<u>Copay</u> applies to first prenatal visit (per pregnancy). <u>Cost sharing</u> does not apply for <u>preventive</u> <u>services</u> . Depending on the type of
	Childbirth/delivery professional services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Additional \$300 <u>deductible Out-of-Network</u> . <u>Preauthorization</u> required; \$500 penalty if not preauthorized <u>Out-of-Network</u> .

Common		What Yo	u Will Pay	Limitations, Exceptions, & Other Important Information	
Medical Event	Services You May Need	Network Provider (you will pay the least)	Out-of-Network Provider (you will pay the most)		
	Home health care	20% coinsurance	50% coinsurance	100 visit limit per benefit period. <u>Preauthorization</u> required; \$500 penalty if not preauthorized <u>Out-of-Network</u> .	
	Rehabilitation services	20% coinsurance	50% coinsurance	Outpatient: Separate 60 visit limits per benefit period for speech and occupational therapies. Combined 60 visit limit per benefit period for physical therapy and chiropractic care.	
If you need help recovering or have other special health	Habilitation services	20% <u>coinsurance</u>	50% coinsurance	Inpatient: Additional \$300 <u>deductible Out-of-</u> <u>Network</u> . 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% <u>coinsurance</u>	50% coinsurance	Additional \$300 <u>deductible</u> <u>Out-of-Network</u> . 100 day limit per benefit period. <u>Preauthorization</u> required; \$500 penalty if not preauthorized <u>Out-of-Network</u> .	
	Durable medical equipment	20% coinsurance	50% coinsurance	<u>Medically necessary</u> rental or purchase at the <u>plan</u> 's discretion.	
	Hospice services	20% coinsurance	50% coinsurance	Additional \$300 <u>deductible</u> <u>Out-of-Network</u> . <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	
	Children's dental check-up	Not Covered	Not Covered	None	

Services Your Plan Generally Does NOT Cover (Check your	policy or plan document for more information and a	a list of any other <u>excluded services</u> .)
Acupuncture	• Hearing aids (limited coverage for children only)	Routine eye care (Adult)
Cosmetic surgery	Infertility treatment	Routine foot care
Dental care (Adult)	Long-term care	 Weight loss programs
• Elective abortion (unless the life of the mother is endangered)		
Other Covered Services (Limitations may apply to these services	vices. This isn't a complete list. Please see your <u>pla</u>	a <u>n</u> document.)
Bariatric surgery (limited coverage only)	• Non-emergency care when traveling outside the	• Private-duty nursing (85 visits per year)
• Chiropractic care (60 visits per benefit period combined with physical therapy)	U.S.	

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 1-800-672-2567, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <u>www.dol.gov/ebsa/healthreform</u>, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <u>www.cciio.cms.gov</u>. Other coverage options may be available to you too, including buying individual insurance coverage through the <u>Health Insurance</u> Marketplace. For more information about the <u>Marketplace</u>, visit <u>www.HealthCare.gov</u> 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 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 1-800-672-2567 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

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 1-800-672-2567. Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-672-2567. Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-672-2567. Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijijgo holne' 1-800-672-2567.

-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:



The total Peg would pay is

\$5,060

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 in-network pre-natal care hospital delivery)	e and a	Managing Joe's type 2 Diab (a year of routine in-network care of controlled condition)		Mia's Simple Fracture (in-network emergency room visit ar up care)	
The plan's overall deductible\$3,000Specialist copayments\$50Hospital (facility) coinsurance20%Other coinsurance20%		 The <u>plan</u>'s overall <u>deductible</u> \$3,000 <u>Specialist copayments</u> \$50 Hospital (facility) <u>coinsurance</u> 20% Other <u>coinsurance</u> 20% 		 The <u>plan</u>'s overall <u>deductible</u> <u>Specialist copayments</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$3,000 \$50 20% 20%
This EXAMPLE event includes services <u>Specialist</u> office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (<i>ultrasounds and blood wo</i> <u>Specialist</u> visit (<i>anesthesia</i>)		This EXAMPLE event includes service <u>Primary care physician</u> office visits (inclu- disease education) <u>Diagnostic tests</u> (blood work) Prescription drugs Durable medical equipment (glucose me	ding	This EXAMPLE event includes servi Emergency room care (including medi supplies) Diagnostic test (x-ray) Durable medical equipment (crutches) Rehabilitation services (physical thera	ical
Total Example Cost	\$12,800	Total Example Cost	\$7,400	Total Example Cost	\$1,900
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
Cost sharing		Cost sharing		Cost sharing	
<u>Deductibles</u>	\$3,000	<u>Deductibles</u>	\$1,900	<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$100	<u>Copayments</u>	\$400	<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$1,900	Coinsurance \$1,100		Coinsurance	\$0
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$60	Limits or exclusions	\$60	Limits or exclusions	\$0

The total Joe would pay is

\$1,800

The total Mia would pay is

\$3,460



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 6984-855.
မွနျမာ Burmese	သင် သို့မဟုတ် သင်ကူညီပေးနေသူတဦးမှ မေးမြန်းလိုသည့် မေးခွန်းများရှိပါက သင့် ဘာသာစကားဖြင့် အကူအညီနှင့် အချက်အလက်များကို အခမဲ့ဖြင့်ရယူနိုင်သည့်အခွင့်အရေးရှိပါသ ည်။ ဘာသာစကား ပြန်ဆိုသူနှင့် စကားပြောရန် သင့် အဖွဲ့ ပင်ကဒ်၏ နောက်ကျောဖက်ပေါ်ရှိ သုံးစွဲသူ ဂန်ဆောင်မှု ဖုန်းနံပါတ်သို့ ခေါ်ဆိုပါ။ အကယ်၍ သင်သည် အဖွဲ့ ပင်တစ်ဦး မဟုတ်ခဲ့ပါက သို့မဟုတ် ကဒ် မရှိပါက 855- 710-6984 သို့ ခေါ်ဆိုပါ။
GWY	ԽՅΖ, D& YGT Ə ՅՅՏՔՅℇУ, ‹ՋԾՐՋℷℬ֍, ԽՅ G& ƏƏY RGPƏSጓՎ D& RGZ4Վ Cℋ GʻOʻԽ℈℈Վ EWOʻY D4∿∿. ƏƏYZ DЛРՎƏY GƏJL&ZPAT, ФРЭЬШՐЪ ƏƏYƏT Oʻ৸GƏY
Cherokee	DƏLƏSPƏY ƏƏY PIT GVP ՃՎՐ DIIMƏJ SA&ጓT Վ4ƏՎ. ЛРӘ ЫРКӘ ՃУ, D& DIMƏƏJ MGOʻƏ ՃУ, ФƏBWՐ֍ DԺԽ 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	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
French	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	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
Hmong	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 그려한 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 ຄົນທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອມີຄຳຖາມ ທ່ານມີສິດຂໍເອົາການຊ່ວຍເຫຼືອ ແລະ ຂໍມູນເປັນນພາສາຂອງທ່ານໄດ້ໂດຍບໍມີຄ່າ
Laotian	ໃຊ້ຈ່າຍ. ເພື່ອລົມກັບນາຍແປພາສາ, ໃຫ້ໂທຫາເບີຝ່າຍບໍລິການລູກຄ້າທີ່ມີຢູ່ດ້ານຫຼັງບັດສະມາຊິກຂອງທ່ານ. ຖ້າທ່ານບໍ່ແມ່ນສະມາຊິກ, ຫຼື ບໍ່ມີບັດ, ໃຫ້ໂທຫາເບີ 855-710-6984.
Diné	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'į' hadeesdzih nínízingo éí kwe'é da'íníishgi áká anídaalwo'ígíí bich'į'
Navajo	hodíílnih, bee nééhózinii bine'déé' bikáá'. Kojí atah naaltsoos ná hadít'éégóó éí doodago bee nééhózinígíí ádingo kojį' hodíílnih 855-710-6984.
فارسی	اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زیان خود، به طور ر ایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با خدمات مشتری به شماره ای که در یشت کارت عضویت شما
Persian	در ج شده است تماس بگیرید. اگر عضو نیستید، یا کارت عضویت ندارید، با شماره 8986-710-855 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.
ใทย	หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีข้อสงสัยใด ๆ คุณมีสิทธิที่จะได้รับความช่วยเหลือ และข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย
Thai	พูดคุยกับล่ามโดยติดต่อฝ่ายบริการลูกค้าที่หมายเลขตามที่ระบุด้านหลังบัตรสมาชิก หากไม่ใช่สมาชิกหรือไม่มีบัตร กรุณาติดต่อที่หมายเลข 855-710-6984
اردو	گر آپ کو، پا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں منت 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، پا آپ کے پاس کارڈ نہیں ہے تو، 1966-710-858 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 thể hội viên của quý vị. Nếu quý vị không phải là hội viên hoặc không có thể, gọi số 855-710-6984.

Health care co We provide free communication aids and servi We do not discriminate on the basis of rac	verage is important find the second s	disability or who needs language assistance.
To receive language or communication	n assistance free of ch	arge, please call us at 855-710-6984.
If you believe we have failed to provide a service, or thin	k we have discriminate	d in another way, contact us to file a grievance.
Office of Civil Rights Coordinator	Phone:	855-664-7270 (voicemail)
300 E. Randolph St. 35th Floor	TTY/TDD: Fax:	855-661-6965 855-661-6960
Chicago, Illinois 60601	Email:	CivilRightsCoordinator@hcsc.net
You may file a civil rights complaint with the U.S. Dep	artment 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 Washington, DC 20201		tal: <u>https://ocrportal.hhs.gov/</u> ocr/portal/lobby.jsf ms: http:// <u>www.hhs.gov/ocr/office/file/index.html</u>

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