Coverage Period: 07/01/2018 – 06/30/2019
Coverage for: Individual + Family Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-468-5744 or visit <a href="https://www.opehw1.com">www.opehw1.com</a>. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at <a href="https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf">www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf</a> or call 1-800-468-5744 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For Network: \$750 Individual / \$1,500 Family For Out-of-Network: \$1,500 Individual / \$3,000 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 drugs</u> , and <u>Network 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 services</u> at <u>www.healthcare.gov/coverage/preventive-care-benefits/</u> .
Are there other deductibles for specific services?	Yes. \$50 <u>deductible</u> on brand-name prescriptions per individual. 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-</u> <u>pocket limit</u> for this <u>plan</u> ?	For Network: \$5,000 Individual / \$10,000 Family For Out-of-Network: \$10,000 Individual / \$20,000 Family Prescription drug limit: \$2,000 Individual / \$4,000 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 <u>out-of-pocket limit?</u>	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-pocket limit</u> .
Will you pay less if you use a <u>network</u> <u>provider</u> ?	Yes. See <a href="www.bcbsok.com">www.bcbsok.com</a> or call 1-800-942-5837 for a list of Blue Preferred <a href="Network providers">Network providers</a>	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan'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 **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common			ı Will Pay	Limitations, Exceptions, & Other
Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information
	Primary care visit to treat an injury or illness	\$20 <u>copay</u> /visit; <u>deductible</u> does not apply	30% coinsurance	None
If you visit a health	Specialist visit	\$50 <u>copay</u> /visit; <u>deductible</u> does not apply	30% coinsurance	None
care <u>provider's</u> office or clinic	Preventive care/screening/ immunization	No Charge; deductible does not apply	30% coinsurance	Specified services limited to one visit per benefit period. 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.
	Diagnostic test (x-ray, blood work)	20% coinsurance	30% coinsurance	Some exceptions and limitations apply. See the Plan's benefit book for additional information.
If you have a test	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	
	Generic drugs	\$10 <u>copay</u> (30 day supply retail)	Reimbursed cost paid minus <u>copay</u>	
If you need drugs to treat your illness or condition  More information about prescription drug coverage is available at www.opehw1.com.	Preferred brand drugs	\$45 <u>copay</u> (30 day supply retail)	Reimbursed cost paid minus copay and brand name deductible	\$50 deductible per person per plan year for Brand name drugs only. As of 10/1/17 the 90 day supply through Mail Order and retail will be: Generic- \$25 / Brand name \$112 A full list of exceptions, limitations & exclusions can be found on the Plan's website at <a href="https://www.opehw1.com">www.opehw1.com</a> .
	Non-preferred brand drugs	\$45 <u>copay</u> (30 day supply retail)	Reimbursed cost paid minus copay and brand name deductible	
	Specialty drugs	\$10 Generic copay (30 day supply, mail order only) \$60 Preferred Brands (30 day supply, mail order only) \$100 Non Preferred Brands (30 day supply, mail order only)	N/A mail order only	

<sup>\*</sup> For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.opehw1.com</u>.

Common Medical Event	Services You May Need	What You <u>Network Provider</u> (You will pay the least)	Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	None
outpatient surgery	Physician/surgeon fees	20% coinsurance	30% coinsurance	None
If you need	Emergency room care	20% coinsurance	20% coinsurance	Additional \$50 copay per visit; waived if admitted.
immediate medical	Emergency medical transportation	20% coinsurance	20% coinsurance	None
attention	<u>Urgent care</u>	\$20 <u>copay</u> /visit; <u>deductible</u> does not apply	30% coinsurance	None
If you have a	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	<u>Preauthorization</u> required; \$1,000 penalty if not preauthorized <u>Out-of-Network</u> .
hospital stay	Physician/surgeon fees	20% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse	Outpatient services	\$20 copay/office visit; deductible does not apply 20% coinsurance for other outpatient services	30% coinsurance	Preauthorization required for certain services.
services	Inpatient services	20% coinsurance	30% coinsurance	<u>Preauthorization</u> required; \$1,000 penalty if not preauthorized <u>Out-of-Network</u> .
If you are pregnant	Office visits	\$20 <u>copay</u> /visit; <u>deductible</u> does not apply	30% coinsurance	Copay applies to first prenatal visit (per pregnancy).  Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Meternity care may
ii you are pregnant	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	Preauthorization required; \$1,000 penalty if not preauthorized Out-of-Network.

<sup>\*</sup> For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.opehw1.com</u>.

Common		What You Will Pay		Limitations, Exceptions, & Other Important	
Medical Event	Services You May Need	Network Provider	Out-of-Network Provider	Information	
	Home health care	(You will pay the least) 20% coinsurance	(You will pay the most) 30% coinsurance	30 visit limit per benefit period.  Preauthorization required; \$1,000 penalty if	
	Tiome nearth care	2070 <u>combandinec</u>	oo / o combutanee	not preauthorized <u>Out-of-Network</u> .	
	Rehabilitation services	20% coinsurance	30% coinsurance	Outpatient: Combined 60 visit limit per benefit period for physical, speech, and occupational therapies.	
If you need help recovering or have other special	Habilitation services	20% coinsurance	30% coinsurance	Inpatient: 30 day limit per benefit period. <u>Preauthorization</u> required; \$1,000 penalty if not preauthorized <u>Out-of-Network</u> .	
health needs	Skilled nursing care	20% coinsurance	30% coinsurance	30 day limit per benefit period. <u>Preauthorization</u> required; \$1,000 penalty if not preauthorized <u>Out-of-Network</u> .	
	Durable medical equipment	20% coinsurance	30% coinsurance	Medically necessary rental or purchase at the plan's discretion.	
	Hospice services	20% coinsurance	30% coinsurance	<u>Preauthorization</u> required; \$1,000 penalty if not preauthorized <u>Out-of-Network</u> .	
	Children's eye exam	Not Covered	Not Covered	Not Covered under medical plan.	
If your child needs dental or eye care	Children's glasses	Not Covered	Not Covered	Not Covered under medical plan.	
dental of eye care	Children's dental check-up	No Charge	No Charge	See the <u>Plan</u> 's benefit book for additional information on coverage.	

<sup>\*</sup> For more information about limitations and exceptions, see the  $\underline{\text{plan}}$  or policy document at  $\underline{\text{www.opehw1.com}}$ .

### **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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Elective abortion (unless mother's life is endangered)
- Hearing aids (limited coverage for children)
- Infertility treatment
- Long-term care

- Routine eye care (Adult, unless offered by your employer)
- Routine foot care (only for diabetic members)
- 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
- Dental care (Adult & child, \$1,500 max/benefit period)
- Most coverage provided outside the United States.
   See www.bcbsok.com
- Non-emergency care when traveling outside the U.S.

Private-duty nursing

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 1-800-468-5744, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <a href="www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a>, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <a href="www.cciio.cms.gov">www.cciio.cms.gov</a>. Other coverage options may be available to you too, including buying individual insurance coverage through the <a href="Health Insurance Marketplace">Health Insurance Marketplace</a>, visit <a href="www.HealthCare.gov">www.HealthCare.gov</a> 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. Additionally, a consumer assistance program can help you file your appeal. Contact the Oklahoma Insurance Department at 1-800-522-0071 or visit www.ok.gov/oid/Consumers/Consumer\_Assistance/.

## Does this <u>plan</u> provide <u>Minimum Essential Coverage</u>? 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.

## **About these Coverage Examples:**



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

# Peg is Having a Baby

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

■ The <u>plan's</u> overall <u>deductible</u>	\$750
■ Specialist copayments	\$50
■ Hospital (facility) coinsurance	20%
Other coinsurance	20%

### This EXAMPLE event includes services like:

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

Total Example Cost	\$12,800
In this example Dea would nave	

m and example, reg means pay.		
Cost sharing		
<u>Deductibles</u>	\$750	
Copayments	\$90	
Coinsurance	\$2,300	
What isn't covered		
Limits or exclusions \$60		
The total Peg would pay is	\$3,200	

# **Managing Joe's type 2 Diabetes**

(a year of routine <u>in-network</u> care of a well-controlled condition)

■ The plan's overall deductible	\$750
Specialist copayments	\$50
■ Hospital (facility) coinsurance	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)

In this example los would nave

Total Evenuela Coat	
Total Example Cost \$7	,400

ili tilis example, Jue would pay.		
Cost sharing		
<u>Deductibles</u> *	\$800	
Copayments	\$1,200	
Coinsurance	\$200	
What isn't covered		
Limits or exclusions \$60		
The total Joe would pay is	\$2,260	

# **Mia's Simple Fracture**

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

■ The <u>plan's</u> overall <u>deductible</u>	\$750
■ Specialist copayments	\$50
■ Hospital (facility) coinsurance	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
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In this example, Mia would pay:

m time example, ma meana pay.	
Cost sharing	
<u>Deductibles</u>	\$750
Copayments	\$200
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,150

<sup>\*</sup>Note: This <u>plan</u> has other <u>deductibles</u> for specific services included in this coverage example. See "Are there other <u>deductibles</u> for specific services?" row above.

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 المضرورية 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 6984-710-858.	
မွနျမာ Burmese	သင် သို့မဟုတ် သင်ကူညီပေးနေသူတဦးမှ မေးမြန်းလိုသည့် မေးခွန်းများရှိပါက သင့် ဘာသာစကားဖြင့် အကူအညီနှင့် အချက်အလက်များကို အခမဲ့ဖြင့်ရယူနိုင်သည့်အခင့်အရေးရှိပါသ ည်။ ဘာသာစကား ပြန်ဆိုသူနှင့် စကားပြောရန် သင့် အဖွဲ့ ဂင်ကဒ်၏ နောက်ကျောဖက်ပေါ် ရှိ သုံးစွဲသူ ဂန်ဆောင်မှု ဖုန်းနံပါတ်သို့ ခေါ်ဆိုပါ။ အကယ်၍ သင်သည် အဖွဲ့ ဂင်တစ်ဦး မဟုတ်ခဲ့ပါက သို့မဟုတ် ကဒ် မရှပါက 855- 710-6984 သို့ ခေါ်ဆိုပါ။	
GWY Cherokee	haz, D6 ygt ө agsprey, corolog, ha ga qoy roposia D6 rgz4a cu gohaga ewoy D4V°V. qoyz Dapaoy gol&zpat, ወbabWob qoyqt oʻhgoy Dolospoy qoy ppt gvp ձao dihaga sacsit a4ga. Apq hbro Љу, D6 dihaga hgoq Љу, ОфbWos Da⁄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 ຄົນທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອມີຄຳຖາມ. ທ່ານມີສິດຂໍເອົາການຊ່ວຍເຫຼືອ ແລະ ຂໍມູນເປັນນພາສາຂອງທ່ານໄດ້ໂດຍບໍ່ມີຄ່າ ໃຊ້ຈ່າຍ. ເພື່ອລົມກັບນາຍແປພາສາ, ໃຫ້ໂທຫາເບີຜ່າຍບໍລິການລູກຄ້າທີ່ມີຢູ່ດ້ານຫຼັງບັດສະມາຊິກຂອງທ່ານ. ຖ້າທ່ານບໍ່ແມ່ນສະມາຊິກ. ຫຼື ບໍ່ມີບັດ, ໃຫ້ໂທຫາເບີ 855-710-6984.	
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídílkidgo, 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'déé' bikáá'. Kojí atah naaltsoos ná hadít'éégóó éí doodago bee nééhózinígíí ádingo koji' hodíílnih 855-710-6984.	
فارسی 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 یشت کارت عضویت در به شده است تماس بگیرید. اگر عضو نیستید، یا کارت عضویت ندارید، با شماره 898-710-555 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>ไ</b> ทย Thai	หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีข้อสงสัยใด ๆ คุณมีสิทธิที่จะได้รับความช่วยเหลือ และข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่ามโดยติ๊ดต่อฝ่ายบริการลูกค้าที่หมายเลขตามที่ระบุด้านหลังบัตรสมาชิก หากไม่ใช่สมาชิกหรือไม่มีบัตร กรุณาติดต่อที่หมายเลข 855-710-6984	
اردو Urdu	گر آب کو، یا کسی ایسے فرد کو جس کی آب مدد کررہے ہیں، کوئی سوال درییس 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 یشت پر درج ہے۔ اگر آپ ممبر نہیں ہیں، یا آپ کے یاس کارڈ نہیں ہے تو، 1898-710-855 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.	

## Health care coverage is important for everyone.

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

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

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

Office of Civil Rights Coordinator

300 E. Randolph St. 35th Floor

Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)

TTY/TDD: 855-661-6965 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

Room 509F, HHH Building 1019 Washington, DC 20201

Phone: 800-368-1019 TTY/TDD: 800-537-7697

Complaint Portal: <a href="https://ocrportal.hhs.gov/ocr/ortal/lobby.jsf">https://ocrportal.hhs.gov/ocr/ortal/lobby.jsf</a> Complaint Forms: <a href="https://www.hhs.gov/ocr/office/file/index.html">https://www.hhs.gov/ocr/office/file/index.html</a>