

University of Oklahoma Self-funded Student Health Plan

Dear Student:

Under the Affordable Care Act, all health insurers and group health plans are required to provide consumers with a Summary of Benefits and Coverage (SBC). The SBC is a summary of the benefits and health coverage offered by a particular plan.

Attached is the SBC for the University of Oklahoma Self-funded Student Health Plan covering plans purchased between 07/01/20 - 08/18/21. In accordance with your College/University, coverage may be purchased for varying periods of time.

All deductibles, out-of-pocket limits, and limits on benefits that are specified in the plan documents and the SBC, begin accruing on the first day of the earliest coverage period the student chooses below, and stop accruing on the last day of the latest coverage period the student chooses below. In instances where those periods are interrupted by coverage periods for which the student declines coverage, the deductibles, out-of-pocket limits, and limits on benefits do not reset when the student resumes coverage. The coverage periods for University of Oklahoma Self-funded Student Health Plan are listed below:

Coverage Periods:

Annual:

OU-HSC Coverage Periods:

Fall 1:	07/01/20 - 12/31/20
Fall 2:	08/15/20 - 12/31/20
Spring:	01/01/21 - 05/31/21
Spring/Summer:	01/01/21 - 06/30/21
Summer 1:	06/01/21 - 06/30/21

Tulsa-Norman Coverage Periods: 08/19/20 - 08/18/21

Fall:	08/19/20 - 01/18/21
Spring:	01/19/21 - 05/16/20
Spring/Summer:	01/19/21 - 08/18/21
Summer:	05/17/21 - 08/18/21
CESL Coverage Periods:	
Fall 1:	08/19/20 - 10/15/20
Fall 2:	10/16/20 - 01/18/21
Spring 1:	01/19/21 - 03/14/21
Spring 2:	03/15/21 - 05/09/21
Summer 1:	05/10/21 - 06/27/21
Summer 2:	06/28/21 - 08/18/21

If you have any questions regarding your coverage or the length of time you purchased, please contact customer service at 855-267-0214.

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 1-855-267-0214 or visit https://ou.myahpcare.com. 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 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?	In-Network/Out Network with Referral: \$500 Individual In-Network/Out Network without Referral: \$1,500 Individual	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.
Are there services covered before you meet your deductible?	Yes. Services at Student Health Center, <u>urgent</u> <u>care</u> , <u>prescription drugs</u> , ambulance, and <u>In-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 <u>deductibles</u> for specific services?	Yes. Annual \$100 <u>prescription drug deductible</u> . Annual \$75 Individual/\$225 Family pediatric dental <u>deductible</u> . 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> ?	In-Network: \$6,600 Individual / \$13,200 Family Out-of-Network: \$15,000 Individual	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</u> , <u>balanced-billed</u> charges, and healthcare 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. See www.bcbsok.com or call 1-855-267-0214 for a list of network providers .	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> ?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .

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

		What You Will Pay		
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	\$35 <u>copay</u> /visit; <u>deductible</u> does not apply	40% coinsurance	All services will be considered Out-of-
	Specialist visit	\$50 <u>copay</u> /visit; deductible does not apply	40% coinsurance	Network unless referral is obtained from the Student Health Center.
If you visit a health care <u>provider's</u> office or clinic	Preventive care/screening/immunization	No Charge; deductible does not apply	Not Covered	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. All services will be considered <u>Out-of-Network</u> unless <u>referral</u> is obtained from the Student Health Center.
16 1 4 4	Diagnostic test (x-ray, blood work)	20% coinsurance	Not Covered	All services will be considered Out-of-
If you have a test	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not Covered	Network unless referral is obtained from the Student Health Center.
If you need drugs to treat your illness	Generic drugs	\$15 <u>copay</u> /30-day supply	Not Covered	Must meet separate \$100 prescription drug deductible before copays apply. Prescriptions limited to 90-day supply at retail pharmacies. At Student Health Center only: \$15 Generic and \$50 Brand. Deductible does not apply. No charge for birth control. Mail order is not covered. Specialty drugs must be obtained from
or condition More information about prescription	Preferred brand drugs	\$50 copay/30-day supply	Not Covered	
drug coverage is available at www.bcbsok.com/me mber/prescriptiondrug	Non-preferred brand drugs	\$50 <u>copay/</u> 30-day supply	Not Covered	
s.html	Specialty drugs	\$15/\$50 <u>copay/</u> 30-day supply	Not Covered	Prime Specialty Pharmacy. Limited to 30-day supply.
If you have	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	All services will be considered <u>Out-of-</u> <u>Network</u> unless <u>referral</u> is obtained
outpatient surgery	Physician/surgeon fees	20% coinsurance	40% coinsurance	from the Student Health Center. Elective abortion is not covered.

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>https://ou.myahpcare.com</u>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
modical Eront		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Emergency room care	\$150 <u>copay</u> /visit plus 20% <u>coinsurance</u>	\$150 <u>copay</u> /visit plus 20% <u>coinsurance</u>	Copay waived if admitted to Hospital.
If you need immediate medical attention	Emergency medical transportation	20% <u>coinsurance;</u> <u>deductible</u> does not apply	20% <u>coinsurance;</u> <u>deductible</u> does not apply	None
attention	<u>Urgent care</u>	\$60 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u> after <u>deductible</u>	None
If you have a	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization required. All services will be considered Out-of-
hospital stay	Physician/surgeon fees	20% coinsurance	40% coinsurance	Network unless referral is obtained from the Student Health Center.
If you need mental health, behavioral health, or substance	Outpatient services	\$35 <u>copay</u> /office visit; <u>deductible</u> does not apply 20% <u>coinsurance</u> other outpatient services	40% <u>coinsurance</u> other outpatient services	Inpatient <u>preauthorization</u> required. All services will be considered Out-of-Network unless <u>referral</u> is obtained
abuse services	Inpatient services	20% coinsurance	40% coinsurance	from the Student Health Center.
	Office visits	\$35 <u>copay</u> /visit; <u>deductible</u> does not apply	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or
If you are pregnant	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% coinsurance	deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Inpatient preauthorization required. All services will be considered Out-of-
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Network unless referral is obtained from the Student Health Center. Pediatric and OB/GYN services do not require a referral.

^{*} For more information about limitations and exceptions, see the $\underline{\text{plan}}$ or policy document at $\underline{\text{https://ou.myahpcare.com}}$

		What You	u Will Pay	
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Home health care	20% coinsurance	Not Covered	All services will be considered <u>Out-of-Network</u> unless <u>referral</u> is obtained from the Student Health Center.
	Rehabilitation services	20% coinsurance	Not Covered	Outpatient: None Inpatient: Preauthorization required. All services will be considered
If you need help	Habilitation services	20% coinsurance	Not Covered	Out-of-Network unless referral is obtained from the Student Health Center.
recovering or have other special health needs	Skilled nursing care	20% coinsurance	Not Covered	All services will be considered <u>Out-of-Network</u> unless <u>referral</u> is obtained from the Student Health Center.
	Durable medical equipment	20% coinsurance	40% coinsurance	Medically necessary, rental or purchase at the plan's discretion.
	Hospice services	20% coinsurance	Not Covered	All services will be considered <u>Out-of-Network</u> unless <u>referral</u> is obtained from the Student Health Center.
	Children's eye exam	No Charge	No Charge; Up to \$30 dollars	Refer to Plan document page 22-27
If your child needs dental or eye care	Children's glasses	No Charge	No Charge; Up to \$75 dollars	Refer to Plan document page 22-27
	Children's dental check-up	20% coinsurance	40% <u>coinsurance</u> deductible does not apply	Refer to Plan document page 28-40

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>https://ou.myahpcare.com</u>

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
- Dental care (Adult)

- Elective abortion (unless the life of the mother is endangered)
- Infertility treatment
- Long-term care

- Routine eye care (Adult)
- Routine foot care (except with diagnosis of diabetes)
- 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

- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (Network only)

Hearing aids (1 per ear per 48-month period)

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 1-866-520-2507. You may also contact your state insurance department at (405) 521-2991. Other coverage options may be available to you too, including buying individual insurance coverage through the <u>Health Insurance Marketplace</u>. 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> <u>Rights</u>: 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: Oklahoma Department of Insurance at (405) 521-2991 or visit <u>www.ok.gov/oid</u>.

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 1-855-267-0214.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-267-0214.

Chinese (中文): 如果需要中文的帮助,请拨打这个号码 1-855-267-0214.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-267-0214.

-----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 <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan</u> 's overall <u>deductible</u>	\$500
■ Specialist copay	\$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, Peg would pay:

Cost Sharing		
<u>Deductibles</u>	\$500	
<u>Copayments</u>	\$500	
<u>Coinsurance</u>	\$2,300	
What isn't covered		
Limits or exclusions \$60		
The total Peg would pay is	\$3,360	

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$500
Specialist copay	\$50
Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (including disease education)
<u>Diagnostic tests</u> (blood work)

Prescription drugs

Durable medical equipment (glucose meter)

Total Example Cost	\$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles*	\$600
Copayments	\$1,400
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$2,360

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$500
■ Specialist copay	\$50
■ Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:

<u>Emergency room care</u> (including medical supplies)

Diagnostic test (x-ray)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$1,900
	1 /

In this example, Mia would pay:

\$500
\$300
\$300
\$0
\$1,100

^{*}Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles 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.

إن كان لديك أو لدى شخص نساعده 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 نكن عضوًا، أو كنت لا تملك بطاقة، فاتصل على 854-710-858.
သင် သို့မဟုတ် သင်ကူညီပေးနေသူတဦးမှ မေးမြန်းလိုသည့် မေးခွန်းများရှိပါက သင့် ဘာသာစကားဖြင့် အကူအညီနှင့် အချက်အလက်များကို အခမဲ့ဖြင့်ရယူနိုင်သည့်အခွင့်အရေးရှိပါသ ည်။ ဘာသာစကား ပြန်ဆိုသူနှင့် စကားပြောရန် သင့် အဖွဲ့ ဂင်ကဒ်၏ နောက်ကျောဖက်ပေါ် ရှိ သုံးစွဲသူ ဂန်ဆောင်မှု ဖုန်းနပါတ်သို့ ခေါ်ဆိုပါ။ အကယ်၍ သင်သည် အဖွဲ့ ဂင်တစ်ဦး မဟုတ်ခဲ့ပါက သို့မဟုတ် ကဒ် မရှိပါက 855- 710-6984 သို့ ခေါ်ဆိုပါ။
haz, do ygt ө agsprey, രാഗയോർ, ha ga bry rgprsiji do rgz4ji cu golaraji ewoy d4√√. bryz djpjay griszpjt, dbabwob brybt o'hgry dblwspry bry ppt gyp ajo dihnrj sawit j4∞j. jpb hbro ay, do dihnrj hgo ay, dobwos dah 855-710-6984.
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。
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.
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.
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.
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.
ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອມີຄຳຖາມ. ທ່ານມີສິດຂໍເອົາການຊ່ວຍເຫຼືອ ແລະ ຂໍມູນເປັນນພາສາຂອງທ່ານໄດ້ໂດຍບໍ່ມີຄ່າ ໃຊ້ຈ່າຍ. ເພື່ອລົມກັບນາຍແປພາສາ, ໃຫ້ໂທຫາເບີຝ່າຍບໍລິການລູກຄ້າທີ່ມີຢູ່ດ້ານຫຼັງບັດສະມາຊິກຂອງທ່ານ. ຖ້າທ່ານບໍ່ແມ່ນສະມາຊິກ, ຫຼື ບໍ່ມີບັດ, ໃຫ້ໂທຫາເບີ 855-710-6984.
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'déé' bikáá'. Kojí atah naaltsoos ná hadít'éégóó éí doodago bee nééhózinígíí ádingo koji' hodíílnih 855-710-6984.
اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زیان 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 ندارید، با شماره 898-710-858 تماس حاصل نمایید. در ج شده است تماس بگیرید. اگر عضو نیستید، یا کارت عضویت ندارید، با شماره 898-710-858 تماس حاصل نمایید.
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.
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.
หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีข้อสงสัยใด ๆ คุณมีสิทธิที่จะได้รับความช่วยเหลือ และข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่ามโดยติดต่อฝ่ายบริการลูกค้าที่หมายเลขตามที่ระบุด้านหลังบัตรสมาชิก หากไม่ใช่สมาชิกหรือไม่มีบัตร กรุณาติดต่อที่หมายเลข 855-710-6984
گر آب کو، یا کسی ایسے فرد کو جس کی آب مدد کر رہے ہیں، کوئی سوال در پیش ہے تو، آب کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، کسٹمر سروس نمیر پر کال کریں جو آپ کے کارڈ کی پشت پر درج ہے۔ اگر آپ ممبر نہیں ہیں، یا آپ کے یاس کارڈ نہیں ہے تو، 1984-710-858 پر کال کریں۔
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: Fax:

855-661-6965 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/oprtal/lobby.jsf Complaint Forms: https://www.hhs.gov/ocr/office/file/index.html