BlueCross BlueShield
of Oklahoma

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 07/01/21 - 08/18/22. 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:

OU-HSC Coverage Periods:

Fall 1:	07/01/21 - 12/31/21
Fall 2:	08/15/21 - 12/31/21
Spring:	01/01/22 - 05/31/22
Spring/Summer:	01/01/22 - 06/30/22
Summer 1:	06/01/22 - 06/30/22

Tulsa-Norman Coverage Periods:

Annual:	08/19/21 - 08/18/22
Fall:	08/19/21 - 01/17/22
Spring:	01/18/22 - 05/15/21
Spring/Summer:	01/18/22 - 08/18/22
Summer:	05/16/22 - 08/18/22

CESL Coverage Periods:

Fall 1:	08/19/21 - 10/17/21
Fall 2:	10/18/21 - 01/17/22
Spring 1:	01/18/22 - 03/20/22
Spring 2:	03/21/22 - 05/11/22
Summer 1:	05/12/22 - 06/29/22
Summer 2:	06/30/22 - 08/18/22

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 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 1-855-267-0214 or at https://ou.myahpcare.com. 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.healthcare.gov/sbc-glossary/ 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 providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Services at Student Health Center, urgent care, prescription drugs, ambulance, and In-Network preventive care 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 www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. Annual $100 prescription drug deductible. Annual $75 Individual/$225 Family pediatric dental deductible. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-Network: $6,600 Individual / $13,200 Family Out-of-Network: $15,000 Individual	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-billing charges, preauthorization penalties, 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. See www.bcbsok.com or call 1-855-267-0214 for a list of network providers.	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?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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
		Network Provider (you will pay the least)	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	$35 copay/visit; deductible does not apply	40% coinsurance	All services will be considered Out-of-Network unless referral is obtained from the Student Health Center.
	Specialist visit	$50 copay/visit; deductible does not apply	40% coinsurance	
	Preventive care/screening/immunization	No Charge; deductible does not apply	Not Covered	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. All services will be considered Out-of-Network unless referral is obtained from the Student Health Center.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not Covered	All services will be considered Out-of-Network unless referral is obtained from the Student Health Center.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not Covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsok.com/member/prescriptiondrugs.html	Generic drugs	$15 copay/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 Prime Specialty Pharmacy. Limited to 30-day supply.
	Preferred brand drugs	$50 copay/30-day supply	Not Covered	

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (you will pay the least)	Out-of-Network Provider (you will pay the most)	
	Non-preferred brand drugs	$50 copay/30-day supply	Not Covered	
	Specialty drugs	$15/$50 copay/30-day supply	Not Covered	

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

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

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsok.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
- 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 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
- Hearing aids (1 per ear per 48-month period)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (Network only)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the plan at 1-866-520-250. 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 1-855-267-0214 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 plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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 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	**$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	**$12,700**

In this example, Peg would pay:

Cost sharing	
Deductibles*	$500
Copayments	$50
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,010**

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost sharing	
Deductibles*	$500
Copayments	$1,200
Coinsurance	$80
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,800**

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost sharing	
Deductibles*	$500
Copayments	$300
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$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.

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 ခေါ် ဆိုပါ။ အကယ်၍ သင်သည် အဖွဲ့ဝင်တစ်ဦး မဟုတ်ခဲ့ပါက သို့မဟုတ် ကဒ် မရှိပါက 855-710-6984 သို့ ခေါ် ဆိုပါ။
ᏣᎳᎩ Cherokee	ᏂᎯᏃ, ᎠᏎ ᏴᏀᎢ Ꮎ ᏑᏍᏚᏢᏍᏋ, ᏜᏛᏅᏇᏍᏕ, ᏂᎯ ᏀᏫ ᎾᏍᎩ ᏒᏀᏢᏍᏚᏐᏗ ᎠᏎ ᏒᏀᏃᏎᏗ ᏟᏌ ᏀᏊᏂᏑᏍᏗ ᎬᏬᏡ ᎠᎽᏉᏉ. ᎾᏍᎩᏃ ᎠᏁᏢᏗᏍᎩ ᏀᏍᏓᏃᏃᏢᏗᎢ, ᏇᎱᏏᏇᏅᏏ ᎾᏍᏴᎾᎢ ᎤᏂᏀᏍᎩ ᎠᎾᏓᏍᏢᏍᎩ ᎾᏍᎩ ᏊᏢᎢ ᏀᏤᏢ ᏜᏗᏅ ᎠᎢᏂᏲᏍᏗ ᏚᎪᏂᎢ ᏗᏎᏍᏗ. ᏗᏢᎾ ᏂᏢᎡᎾ ᏜᏴ, ᎠᏎ ᎠᎢᏂᏲᏍᏗ ᏂᏀᏛᎾ ᏜᏴ, ᏇᏍᏏᏇᏅᏕ ᎠᏫᏂ 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 ຂໍ້ມູນເປັນພາສາຂອງທ່ານໄດ້ໂດຍບໍ່ມີຄ່າ ໃຊ້ຈ່າຍ. ເພື່ອລົມກັບນາຍແປພາສາ, ໃຫ້ໂທຫາເບີຝ່າຍບໍລິການລູກຄ້າທີ່ມີຢູ່ດ້ານຫຼັງບັດສະມາຊິກຂອງທ່ານ. ຖ້າທ່ານບໍ່ແມ່ນສະມາຊິກ, ຫຼື ບໍ່ມີບັດ, ໃຫ້ໂທຫາເບີ 855-710-6984.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł. Ata' halne'í bich'į' hadeesdzih nínízingo éí kwe'é da'íníishgi áká anídaalwo'ígíí bich'į' hodíílnih, bee nééhózinii bine'dę́ę́' bikáá'. Kojí atah naaltsoos ná hadít'éégóó éí doodago bee nééhózinígíí ádingo kojį' 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 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.

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	Phone:	855-664-7270 (voicemail)
300 E. Randolph St.	TTY/TDD:	855-661-6965
35th Floor	Fax:	855-661-6960
Chicago, IL 60601	Email:	CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services	Phone:	800-368-1019
200 Independence Avenue SW	TTY/TDD:	800-537-7697
Room 509F, HHH Building 1019	Complaint Portal:	https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Washington, DC 20201	Complaint Forms:	http://www.hhs.gov/ocr/office/file/index.html