**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 1-866-355-5999 or at www.bcbstx.com/trsactivecare. 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: $1,000 Individual / $3,000 Family<br>Out-of-Network: $2,000 Individual / $6,000 Family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Services that charge a copayment, prescription drugs, and certain 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. $200 prescription drug deductible. Does not apply to generic drugs. 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: $7,900 Individual / $15,800 Family<br>Out-of-Network: $23,700 Individual / $47,400 Family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billed charges, 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.bcbstx.com/trsactivecare or call 1-866-355-5999 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?** | No. | You can see the specialist you choose without a referral. |

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

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-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 | $30 copayment/visit; deductible does not apply; except 20% coinsurance for office surgery | 40% coinsurance after deductible | Includes Internist, General Physician, Family Practitioner, Pediatrician, Behavioral Health Physicians, or Gynecologist.<br>Virtual visits may be available, please refer to your plan policy for more details; TRS Virtual Health Medical Consult Fee: Teladoc $12, RediMD $0. |
| | Specialist visit | $70 copayment/visit; deductible does not apply; except 20% coinsurance for office surgery | 40% coinsurance after deductible | None |
| | Preventive care/screening/immunization | No Charge; deductible does not apply; except $30 PCP/$70 SPC copayment/visit for hearing or eye exam | 40% coinsurance after deductible | TRS Preventive Care – https://www.trs.texas.gov/Pages/healthcare_covered_preventive_care.aspx.<br>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.<br>1 per plan year limitation for Hearing and Eye exam. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No Charge; deductible does not apply | 40% coinsurance after deductible | Outpatient Lab/X-ray services performed at a hospital apply 20% coinsurance after deductible. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance after deductible | 40% coinsurance after deductible | Preauthorization may be required.<br>$100 copayment per procedure is assessed when services are received in a hospital setting or imaging center. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at www.caremark.com | Generic drugs | Copayment/prescription, deductible doesn't apply: $20 (Retail first fill), $35 (Retail second fill - maintenance drugs), $45 (Mail Order or Retail-Plus) | Copayment/prescription, deductible doesn't apply: $20 (Retail first fill), $35 (Retail second fill - maintenance drugs), $45 (Mail Order or Retail-Plus) | Covers 31-day supply (Retail), 60-90 day supply (Mail Order & Retail-Plus). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in-network. Precertification & step therapy required. Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written. Out-of-Network: reimbursement is the allowed amount for what would have been charged by a network pharmacy less the copayment after the drug deductible is met. |
| | Preferred brand drugs | Copayment/prescription: 25% coinsurance, after specific deductible: minimum $40/maximum $80 (Retail first fill), minimum $60/maximum $120 (Retail second fill - maintenance drugs), minimum $105/maximum $210 (Mail Order or Retail-Plus) | Copayment/prescription: 25% coinsurance, after specific deductible: minimum $40/maximum $80 (Retail first fill), minimum $60/maximum $120 (Retail second fill - maintenance drugs), minimum $105/maximum $210 (Mail Order or Retail-Plus) | |
| | Non-preferred brand drugs | Copayment/prescription: 50% coinsurance, after specific deductible: minimum $100/maximum $200 (Retail first fill), minimum $105/maximum $210 (Retail second fill - maintenance drugs), minimum $215/maximum $430(Mail Order or Retail-Plus) ) | Copayment/prescription: 50% coinsurance, after specific deductible: minimum $100/maximum $200 (Retail first fill), minimum $105/maximum $210 (Retail second fill - maintenance drugs), minimum $215/maximum $430(Mail Order or Retail-Plus) ) | |
| | Specialty drugs | 30% coinsurance after specific deductible, minimum $200/maximum $900 | 30% coinsurance after specific deductible, minimum $200/maximum $900 | All Specialty drugs must be filled at CVS Specialty Pharmacy. Retail not covered. 31-day supply limit.<br>The PrudentRx Copay Program allows you to get select specialty medications at no cost to you. That means $0 out-of-pocket (OOP) for any medications on your plan's exclusive Specialty Drug List when you fill by CVS Specialty®. PrudentRx can be reached at 1-800-578-4403 to address any questions |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | | | | regarding the PrudentRx Copay Program. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $150 copayment/visit plus 20% coinsurance after deductible | $150 copayment/visit plus 40% coinsurance after deductible | None |
| | Physician/surgeon fees | 20% coinsurance after deductible | 40% coinsurance after deductible | None |
| **If you need immediate medical attention** | Emergency room care | Facility Charges: $250 copayment/visit plus 20% coinsurance after deductible<br>ER Physician Charges: 20% coinsurance after deductible | Facility Charges: $250 copayment/visit plus 20% coinsurance after deductible<br>ER Physician Charges: 20% coinsurance after deductible | Free Standing Emergency Rooms apply a $500 copayment per visit prior to the deductible. Once the deductible and copayment are applied, there is a 20% coinsurance for In-Network services and 40% coinsurance for Out-of- Network services.<br>40% coinsurance for non-emergency use out-of-network. |
| | Emergency medical transportation | 20% coinsurance after deductible | 20% coinsurance after deductible | Ground and air transportation covered.<br>Non-emergency transport: not covered, except if preauthorized. |
| | Urgent care | $50 copayment/visit; deductible does not apply | 40% coinsurance after deductible | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $150 copayment/day first 5 days plus 20% coinsurance after deductible | 40% coinsurance after deductible | Member pays the balance of covered charges over $500 per day for out-of-network facilities.<br>Maximum/plan year per individual facility copayment: $2,250.<br>Preauthorization is required; $250 penalty if not preauthorized Out-of-Network. |
| | Physician/surgeon fees | 20% coinsurance after deductible | 40% coinsurance after deductible | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $30 copayment/visit; deductible does not apply 20% coinsurance after deductible for other outpatient services | 40% coinsurance after deductible | Certain services must be preauthorized; refer to benefits booklet for details. Virtual visits are available through TRS-Virtual Health, please refer to your plan policy for more details; Psychiatrist (Initial Visit) $70.00, Psychiatrist (Ongoing Visit) $70.00, Psychologist, Licensed Clinical Social Worker $70.00. |
| | Inpatient services | $150 copayment/day first 5 days plus 20% coinsurance after deductible | 40% coinsurance after deductible | Member pays the balance of covered charges over $500 per day for out-of-network facilities. Maximum/plan year per individual facility copayment: $2,250. Preauthorization is required; $250 penalty if not preauthorized Out-of-Network. |
| **If you are pregnant** | Office visits | $30 copayment/visit; deductible does not apply | 40% coinsurance after deductible | Copayment 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. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 20% coinsurance after deductible | 40% coinsurance after deductible | |
| | Childbirth/delivery facility services | $150 copayment/day first 5 days plus 20% coinsurance after deductible | 40% coinsurance after deductible | Member pays the balance of covered charges over $500 per day for out-of-network facilities. Maximum/plan year per individual facility copayment: $2,250. Preauthorization is required; $250 penalty if not preauthorized Out-of-Network. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-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 after deductible | 40% coinsurance after deductible | Member pays the balance of charge in excess of $500 per day.<br>Limited to 60 visits per plan year.<br>Preauthorization may required. |
| | Rehabilitation services | $70 copayment/visit; deductible does not apply | 40% coinsurance after deductible | 20% coinsurance based on the place of treatment services received. This includes physical therapy, occupational therapy, and speech therapy. |
| | Habilitation services | $70 copayment/visit; deductible does not apply | 40% coinsurance after deductible | |
| | Skilled nursing care | 20% coinsurance after deductible | 40% coinsurance after deductible | Member pays the balance of covered charges over $500 per day for out-of-network skilled nursing care.<br>Limited to 25 days per plan year.<br>Preauthorization is required. |
| | Durable medical equipment | 20% coinsurance after deductible | 40% coinsurance after deductible | Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse. |
| | Hospice services | 20% coinsurance after deductible | 40% coinsurance after deductible | Member pays the balance of charge in excess of $500 per day.<br>Preauthorization is required. |
| **If your child needs dental or eye care** | Children's eye exam | $70 copayment/visit; deductible does not apply | 40% coinsurance after deductible | None |
| | Children's glasses | Not Covered | Not Covered | None |
| | Children's dental check-up | Not Covered | Not Covered | None |

## 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.)**

- Cosmetic surgery
- Dental care (Adult and children)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care (with the exception of person with diagnosis of diabetes)
- Weight loss programs (except for required preventive services)

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

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Acupuncture (in lieu of anesthesia and nausea during pregnancy)
- Bariatric surgery (Limited to Blue Distinction Center Plus. 20% after deductible and $150 copayment day. $5,000 per procedure copayment for professional charges.)
- Chiropractic care (35 visits per plan year)
- Hearing aids ($1,000 maximum/36 months for members age 19 and older)
- Infertility treatment (Limited to the diagnosis & treatment of underlying medical condition)
- Private-duty nursing
- Routine eye care (Adult, 1 routine eye exam per plan year)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the plan at 1-866-355-5999, 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 Texas at 1-866-355-5999 or visit www.bcbstx.com/trsactivecare, 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 Texas Department of Insurance's Consumer Health Assistance Program at 1-800-252-3439 or visit www.texashealthoptions.com.

**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 1-866-355-5999.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-355-5999.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-355-5999.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-355-5999.

*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 | $1,000 |
| Specialist copayment | $70 |
| 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 | $1,000 |
| Copayments | $200 |
| Coinsurance | $2,000 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,260** |

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

| | |
|---|---|
| The plan's overall deductible | $1,000 |
| Specialist copayment | $70 |
| 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 | $1,000 |
| Copayments | $500 |
| Coinsurance | $700 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$2,220** |

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

| | |
|---|---|
| The plan's overall deductible | $1,000 |
| Specialist copayment | $70 |
| 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 | $1,000 |
| Copayments | $700 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,800** |

*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 Texas

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<br>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. |
| 繁體中文<br>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<br>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<br>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. |
| ગુજરાતી<br>Gujarati | જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. દુભાષિયા સાથે વાત કરવા માટે, તમારા સભ્યપદના કાર્ડની પાછળ આપેલ ગ્રાહક સેવા નંબર પર કૉલ કરો. જો આપ સભ્યપદ ના ધરાવતા હોવ, અથવા આપની પાસે કાર્ડ નથી તો 855-710-6984 નંબર પર કૉલ કરો. |
| हिंदी<br>Hindi | यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए, अपने सदस्य कार्ड के पीछे दिए गए ग्राहक सेवा नंबर पर कॉल करें। यदि आप सदस्य नहीं हैं, या आपके पास कार्ड नहीं है, तो 855-710-6984 पर कॉल करें। |
| 日本語<br>Japanese | ご本人様、またはお客様の身の回りの方でも、ご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、メンバーカードの裏のカスタマーサービス番号までお電話ください。メンバーでない場合またはカードをお持ちでない場合は 855-710-6984 までお電話ください。 |
| 한국어<br>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<br>Laotian | ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກໍາລັງໃຫ້ການຊ່ວຍເຫຼືອມີຄໍາຖາມ, ທ່ານມີສິດຂໍເອົາການຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໄດ້ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອລົມກັບນາຍແປພາສາ, ໃຫ້ໂທຫາເບີຝ່າຍບໍລິການລູກຄ້າທີ່ມີຢູ່ດ້ານຫຼັງບັດສະມາຊິກຂອງທ່ານ. ຖ້າທ່ານບໍ່ແມ່ນສະມາຊິກ, ຫຼື ບໍ່ມີບັດ, ໃຫ້ໂທຫາເບີ 855-710-6984. |
| Diné<br>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'į' hadeesdzih nínízingo éí kwe'é da'íníishgi áká anídaalwo'ígíí bich'į' hodíílnih, bee nééhózinii bine'dęę' bikáá'. Kojí atah naaltsoos ná hadít'éégóó éí doodago bee nééhózinígíí ádingo kojį' hodíílnih 855-710-6984. |
| فارسی<br>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. |
| Русский<br>Russian | Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы поговорить с переводчиком, позвоните в отдел обслуживания клиентов по телефону, указанному на обратной стороне вашей карточки участника. Если вы не являетесь участником или у вас нет карточки, позвоните по телефону 855-710-6984. |
| Español<br>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<br>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. |
| اردو<br>Urdu | اگر 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<br>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.

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| 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:

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| 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 |