





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, visit <http://chibenefitplans.net> or call your local HR. 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](http://www.healthcare.gov/sbc-glossary) or call your local HR, to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	CommonSpirit Health Facility: \$3,200 individual /\$6,400 family per calendar year In-Network <u>Provider</u> : \$3,200 individual /\$6,400 family per calendar year Out-of-Network <u>Provider</u> : \$6,000 individual /\$12,000 family per calendar year	Generally, you must pay all 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. Well-child care, preventive drug list medications and <u>preventive care</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	CommonSpirit Health Facility: \$5,000 individual /\$10,000 family per calendar year In-Network <u>Provider</u> : \$5,000 individual /\$10,000 family per calendar year Out-of-Network <u>Provider</u> : \$12,000 individual /\$24,000 family per calendar year	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, pre-service review penalties, <u>balance-billed charges</u> , and health care 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. You have two levels for network providers. Enhanced Network Level: CommonSpirit Health Facilities In-Network Level: PPO See <a href="http://www.bcbsil.com/chi">www.bcbsil.com/chi</a> call 1.866.776.4244 for a list of <u>network providers</u> .	This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's network. You will pay the most if you use an out-of-network <u>provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an out-of-network <u>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 <u>specialist</u> you choose without a <u>referral</u> .


 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
		CommonSpirit Health Facility (You will pay the least)	In-Network Provider (You will pay more)	Out-of- Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	Not applicable	20% <u>coinsurance</u>	60% <u>coinsurance</u>	Primary Care Physicians (PCP) are defined as General and Family Practice, Internal Medicine, OB/ GYN, Pediatricians, Nurse Practitioners and PAs. Level 1 services are facility services received at; and, provided by physicians recognized by CommonSpirit Health Level 2 services are in-network <u>providers</u> . Level 3 are out-of- network <u>providers</u> .
	<u>Specialist</u> visit	Not applicable	25% <u>coinsurance</u>	60% <u>coinsurance</u>	Applies to Non-PCP <u>provider</u> types.
	<u>Preventive care/screening/immunization</u>	No charge <u>Deductible</u> does not apply	No charge <u>Deductible</u> does not apply	No charge <u>Deductible</u> does not apply	See www.healthcare.gov for preventive care guidelines. There may be additional benefits available. See your Employer Summary Plan Description for details. 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.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Physician: N/A Facility: 15% <u>coinsurance</u>	25% <u>coinsurance</u>	60% <u>coinsurance</u>	For a test in a <u>provider's</u> office or clinic, your cost is included in the cost-share listed above.
	Imaging (CT/PET scans, MRIs)	Physician: N/A Facility: 15% <u>coinsurance</u>	25% <u>coinsurance</u>	60% <u>coinsurance</u>	None


For more information about limitations and exceptions, see your plan document or call your local HR.

 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
		CommonSpirit Health Facility (You will pay the least)	In-Network Provider (You will pay more)	Out-of- Network Provider (You will pay the most)	
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <b>prescription drug coverage</b> is available at <a href="http://www.cap-rx.com">www.cap-rx.com</a></p> <p>For specialty prescriptions, go to <a href="http://www.dignityhealth.org/arizona/locations/stjosephs/services/pharmacy">www.dignityhealth.org/arizona/locations/stjosephs/services/pharmacy</a></p>	Generic drugs	Retail: \$5 <u>copay</u> Home delivery: \$12.50 <u>copay</u>	Retail: \$10 <u>copay</u> Home delivery: \$25 <u>copay</u>	Retail: 60% <u>coinsurance</u> Home delivery: N/A	<p>Covers up to a 30-day supply from an in-network retail pharmacy or a 90-day supply from a home delivery pharmacy.</p> <p>If you fill a brand-name prescription when a generic equivalent is available, you will pay the brand-name <u>coinsurance</u> plus the difference between the generic and brand-name.</p> <p>Maintenance medications must be filled for a 90-day supply using a CommonSpirit Health-owned pharmacy, the CommonSpirit Health home delivery pharmacy, the Capital Rx home delivery pharmacy, or a Walgreens retail pharmacy.</p> <p>Any combination of diabetic supplies and insulin purchased at a <u>network</u> retail pharmacy on the same day are subject to one <u>copayment</u> or the applicable <u>coinsurance</u> amount. Additional <u>copayment/ coinsurance</u> amounts will apply to any combination of supplies purchased separately from an insulin purchase.</p> <p>Specialty prescriptions must be processed through the CommonSpirit Health Specialty Pharmacy. If the CommonSpirit Health Specialty Pharmacy can't fill your medication, your prescription will be routed to the Capital Rx Specialty Pharmacy partner or you may call 1.844.306.6254.</p>
	Preferred brand drugs	15% <u>coinsurance</u> Retail: \$20 min/\$55 max Home delivery: \$50 min/\$87.50 max	30% <u>coinsurance</u> Retail: \$40 min/\$110 max Home delivery: \$100 min/\$175 max	Retail: 60% <u>coinsurance</u> Home delivery: N/A	
	Non-preferred brand drugs	25% <u>coinsurance</u> Retail: \$32.50 min/\$80 max Home delivery: \$80 min/\$162.50 max	50% <u>coinsurance</u> Retail: \$65 min/\$160 max Home delivery: \$160 min/\$325 max	Retail: 60% <u>coinsurance</u> Home delivery: N/A	
	<u>Specialty drugs</u>	Refer to above costs	Refer to above costs	Refer to above costs	

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		CommonSpirit Health Facility (You will pay the least)	In-Network Provider (You will pay more)	Out-of- Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% <u>coinsurance</u>	25% <u>coinsurance</u>	60% <u>coinsurance</u>	Waive <u>coinsurance</u> on first colonoscopy of the benefit period.
	Physician/surgeon fees	Not applicable	25% <u>coinsurance</u>	60% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>copay</u> per facility per date of service for facility and <u>physician(s) services</u> combined	\$200 <u>copay</u> per facility per date of service for facility and <u>physician(s) services</u> combined	\$200 <u>copay</u> per facility per date of service for facility and <u>physician(s) services</u> combined	50% <u>coinsurance</u> applies to non-emergency medical services. For emergency medical conditions treated out-of-network, you may be balance billed. Dental treatment for accidental injury is limited to care completed within 12 months of the injury.
	<u>Emergency medical transportation</u>	No charge after <u>deductible</u>	No charge after <u>deductible</u>	No charge after <u>deductible</u>	Ambulance services received from an out-of-network provider may balance bill the difference in the billed amount and the allowed amount.
	<u>Urgent care</u>	\$75 <u>copay</u> per <u>provider</u> per date of service	\$75 <u>copay</u> per <u>provider</u> per date of service	\$75 <u>copay</u> per <u>provider</u> per date of service	None
If you have a hospital stay	Facility fee (e.g., hospital room)	15% <u>coinsurance</u>	25% <u>coinsurance</u>	60% <u>coinsurance</u>	Reduction for failure to pre-certify out-of-network services is \$500 per admission.
	Physician/surgeon fees	Not applicable	25% <u>coinsurance</u>	60% <u>coinsurance</u>	None

 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
		CommonSpirit Health Facility (You will pay the least)	In-Network Provider (You will pay more)	Out-of- Network Provider (You will pay the most)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Physician: N/A Facility: 15% <u>coinsurance</u>	Office PCP: 20% <u>coinsurance</u> Facility: 25% <u>coinsurance</u>	60% <u>coinsurance</u>	None
	Inpatient services	Physician: N/A Facility: 15% <u>coinsurance</u>	25% <u>coinsurance</u>	60% <u>coinsurance</u>	Residential treatment is covered with no 24-hour nursing supervision requirement. Reduction for failure to pre-certify out-of-network services is \$500 per admission.
<b>If you are pregnant</b>	Office visits	Not applicable	Office PCP: 20% <u>coinsurance</u> Facility: 25% <u>coinsurance</u>	60% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply to certain preventive services. Any in-network services that fall outside of preventive care/routine obstetric care, will pay at the most appropriate benefit in the plan document.
	Childbirth/delivery professional services	Not applicable	25% <u>coinsurance</u>	60% <u>coinsurance</u>	Benefits shown reflect OB/GYN practitioner services which may be globally billed at time of delivery for pre-natal, post-natal and delivery services. Not all services are billed globally.
	Childbirth/delivery facility services	15% <u>coinsurance</u>	25% <u>coinsurance</u>	60% <u>coinsurance</u>	None

 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
		CommonSpirit Health Facility (You will pay the least)	In-Network Provider (You will pay more)	Out-of- Network Provider (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	Physician: N/A 15% <u>coinsurance</u>	25% <u>coinsurance</u>	60% <u>coinsurance</u>	None
	<u>Rehabilitation services</u>	Physician: N/A Facility: 15% <u>coinsurance</u>	Office PCP: 20% <u>coinsurance</u> Office Non-PCP and Facility: 25% <u>coinsurance</u>	60% <u>coinsurance</u>	In-Network and Out-of-Network outpatient/office physical, speech and occupational therapies are limited to 30 combined visits per calendar year. CommonSpirit Health Facilities aka Enhanced Network is not subject to 30-visit maximum.
	<u>Habilitation services</u>	Physician: N/A Facility: 15% <u>coinsurance</u>	Office PCP: 20% <u>coinsurance</u> Office Non-PCP and Facility: 25% <u>coinsurance</u>	60% <u>coinsurance</u>	In-Network and Out-of-Network outpatient/office physical, speech and occupational therapies are limited to 30 combined visits per calendar year. CommonSpirit Health Facilities aka Enhanced Network is not subject to 30-visit maximum.
	<u>Skilled nursing care</u>	Physician: N/A Facility: 15% <u>coinsurance</u>	25% <u>coinsurance</u>	60% <u>coinsurance</u>	Reduction for failure to pre-certify out-of-network services is \$500 per admission.
	<u>Durable medical equipment</u>	Not applicable	25% <u>coinsurance</u>	60% <u>coinsurance</u>	One wig per calendar year is covered when related to medical condition. 2 pair of foot orthotics covered per calendar year.
	<u>Hospice services</u>	Physician: N/A Facility: 15% <u>coinsurance</u>	25% <u>coinsurance</u>	60% <u>coinsurance</u>	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	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
- Custodial care – in home or facility
- Dental care
- Eye exam
- Glasses
- Hearing aids
- Long-term care
- Massage Therapy
- Routine eye care – Adult
- Routine foot care
- Weight loss programs

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

- Acupuncture (10 visits per calendar year)
- Bariatric surgery
- Chiropractic care (20 visits per calendar year)
- Infertility treatment (\$15,000 LTM, \$5,000 LTM for infertility medications, excludes some services)
- Private-duty nursing – short-term intermittent home skilled 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.S. Department of Labor, Employee Benefits Security Administration at 1.866.444.EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). 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](http://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 on how 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: your local HR; Blue Cross and Blue Shield of Illinois at 1.866.766.4244 or visit [www.bcbsil.com](http://www.bcbsil.com); or Employee Benefits Security Administration at 1.866.444.EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance at 1.877.527.9431 or visit <http://insurance.illinois.gov>.

### 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.

—————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)

■ <b>The plan's overall deductible</b>	\$3,200
■ <b>Specialist coinsurance</b>	20%
■ <b>Hospital (facility) coinsurance</b>	25%
■ <b>Other coinsurance</b>	25%

**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)

<b>Total Example Cost</b>	<b>\$12,840</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$3,200
Copayments	\$0
Coinsurance	\$2,395
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$5,655</b>

### Managing Joe's type 2 Diabetes

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

■ <b>The plan's overall deductible</b>	\$3,200
■ <b>Primary care coinsurance</b>	20%
■ <b>Hospital (facility) coinsurance</b>	25%
■ <b>Other coinsurance</b>	25%

**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)

<b>Total Example Cost</b>	<b>\$7,460</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$3,200
Copayments	\$0
Coinsurance	\$1,050
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$4,310</b>

### Mia's Simple Fracture

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

■ <b>The plan's overall deductible</b>	\$3,200
■ <b>Hospital (facility) coinsurance</b>	25%
■ <b>Other coinsurance</b>	25%

**This EXAMPLE event includes services like:**

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

<b>Total Example Cost</b>	<b>\$2,010</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$2,010
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,010</b>





## BlueCross BlueShield of Illinois

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 تساعد أسئلة، فذلك 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، فتصل على 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.
Ελληνικά Greek	Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να μιλήσετε σε έναν διερμηνέα, καλέστε τον αριθμό εξπηρέτησης πελατών που αναγράφεται στο πίσω μέρος της κάρτας μέλους σας. Εάν δεν είστε μέλος ή δεν έχετε κάρτα, καλέστε τον αριθμό 855-710-6984.
ગુજરાતી 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 કોલ કરો. જો આપ સભ્યપદ ના ધરાવતા હોવ, અથવા આપની પાસે કાર્ડ નથી તો 855-710-6984 નંબર પર કોલ કરો.
हिंदी 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।
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il servizio clienti al numero riportato sul lato posteriore della tua tessera di socio. Se non sei socio o non possiedi una tessera, puoi chiamare il numero 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 있는 고객 서비스 번호로 전화하십시오. 회원이 아니시거나 카드가 없으시면 855-710-6984 으로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago ła'da biká anánílwo'ígíí, na'idííkidgo, ts'ídá bee ná ahóótí'i' t'áá níí'k'e níká a'doolwoł. Ata' halne'i bich'i'i' hadeesdzih nínízingo éí kwe'é da'íníshgi áká anídaalwo'ígíí bich'i'i' hodiílnih, bee nééhózinii bine'déé' bikáá'. Kojí atah naaltsoos ná hadít'éégóó éí doodago bee nééhózinígíí ádingo kojí' hodiílnih 855-710-6984.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiegokolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer podany na odwrocie karty członkowskiej. Jeżeli nie jesteś członkiem lub nie masz przy sobie karty, zadzwoń pod numer 855-710-6984.
Русский 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 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.
اردو Urdu	گر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کر رہے 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  
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](mailto: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/portal/lobby.jsf>  
Complaint Forms: <http://www.hhs.gov/ocr/office/file/index.html>