


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 1-888-371-1928 or visit [www.bcbsnm.com](http://www.bcbsnm.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.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf](http://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:
<b>What is the overall deductible?</b>	Blue Preferred Plus (BPP) <u>Provider</u> : \$500 Individual/\$1,000 2-person/\$1,500 Family <u>Preferred Provider</u> : \$2,000 Individual/\$4,000 2-person/\$6,000 Family <u>Non-Preferred Provider</u> : \$4,000 Individual/\$8,000 2-person/\$12,000 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan 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> .
<b>Are there services covered before you meet your deductible?</b>	Yes. Certain <u>prescription drugs</u> , in-network office visits that charge a <u>copay</u> , in-network <u>diagnostic tests</u> , and certain in-network preventive care 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> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	Blue Preferred Plus (BPP) <u>Provider</u> : \$3,000 Individual/\$6,000 2-person/\$9,000 Family <u>Preferred Provider</u> : \$4,500 Individual/\$7,875 2-person/\$11,250 Family <u>Non-Preferred Provider</u> : \$8,500 Individual /\$14,875 2-person/\$21,250 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. The out-of-pocket limit cross-applies between Tier 1 (Blue Preferred Plus) providers and Tier 2 (Blue Nationwide PPO Preferred) providers. It does not cross-apply with Tier 3 (out-of-network, Non-Preferred Provider) services.
<b>What is not included in the out-of-pocket limit?</b>	<u>Premiums</u> , <u>prescription drug payments</u> , <u>balance-billed charges</u> , penalty amounts, and health care this <u>plan</u> doesn't cover. In addition, certain specialty pharmacy drugs are considered non-essential health benefits under the Affordable Care Act (ACA), and fall outside the out-of-pocket limits.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a network provider?</b>	Yes, and you will pay the least if you use Tier 1 (Blue Preferred Plus) providers. See <a href="http://www.bcbsnm.com">www.bcbsnm.com</a> or call 1-800-432-0750 to locate Tier 1 and Tier 2 <u>network providers</u> .	You pay the least if you use a Tier 1 <u>in-network provider</u> . You pay more if you use a Tier 2 <u>in-network provider</u> . You will pay the most if you use an <u>out-of-network provider</u> (Tier 3), and you might receive a bill from a Tier 3 <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays ( <u>balance</u>

		billing). Be aware, your Tier 1 or Tier 2 <u>in-network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work), and your Tier 1 provider might use a Tier 2 provider for some services.
<b>Do you need a referral to see a specialist?</b>	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
		BPP Provider (you will pay the least)	Preferred Provider	Non-Preferred Provider (you will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$15 <u>copay</u> /visit; <u>deductible</u> does not apply	\$50 <u>copay</u> /visit; <u>deductible</u> does not apply	50% <u>coinsurance</u> after <u>deductible</u>	None
	<u>Specialist</u> visit	\$40 <u>copay</u> /visit; <u>deductible</u> does not apply	\$75 <u>copay</u> /visit; <u>deductible</u> does not apply	50% <u>coinsurance</u> after <u>deductible</u>	None
	<u>Preventive care/screening/immunization</u>	No Charge; <u>deductible</u> does not apply	No Charge; <u>deductible</u> does not apply	50% <u>coinsurance</u> after <u>deductible</u>	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.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	No Charge; <u>deductible</u> does not apply	No Charge; <u>deductible</u> does not apply	50% <u>coinsurance</u> after <u>deductible</u>	None
	Imaging (CT/PET scans, MRIs)	\$100 copay/day plus 20% <u>coinsurance</u> after <u>deductible</u>	\$100 copay/day plus 40% <u>coinsurance</u> after <u>deductible</u>	\$100 copay/test plus 50% <u>coinsurance</u> after <u>deductible</u>	Requires <u>preauthorization</u> .

\* For more information about limitations and exceptions, see the plan or policy document at [www.bcbsnm.com](http://www.bcbsnm.com).

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		BPP Provider (you will pay the least)	Preferred Provider	Non-Preferred 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 from Express Scripts at 1-866-563-9297 or <a href="http://www.express-scripts.com">www.express-scripts.com</a></p>	Generic drugs	Retail: 20% <a href="#">coinsurance</a> , minimum \$10 and maximum \$25 (up to 34-day supply); Home delivery and Walgreens: \$25 <a href="#">copayment</a> (up to 90-day supply)		Not covered	Prescription drug benefits are administered for Albuquerque Public Schools by Express Scripts.
	Preferred brand drugs	Retail: 30% <a href="#">coinsurance</a> , minimum \$35 and maximum \$65 (up to 34-day supply); Home delivery and Walgreens: \$70 <a href="#">copayment</a> (up to 90-day supply)		Not covered	Insulin and Diabetic Supplies: \$0 copayment
	Non-preferred brand drugs	Retail: 40% <a href="#">coinsurance</a> , minimum \$70 and maximum \$140 (up to 34-day supply); Home delivery and Walgreens: \$150 <a href="#">copayment</a> (up to 90-day supply)		Not covered	Maintenance (long-term) medications: A maximum of two 30-day fills of maintenance medications are allowed at a retail pharmacy. Then, maintenance medications require a 90-day fill either via Express Scripts home delivery or at a Walgreens pharmacy.
	<p><u>Specialty drugs</u></p> <p>Specialty medications must be filled through Accredo, the Express Scripts home delivery specialty pharmacy</p>	<p>30-day supply of specialty medications</p> <p>\$70 for generic specialty medications \$100 for preferred brand specialty medications \$150 for non-preferred brand specialty medications</p> <p>Copays for certain specialty medications may be set to the maximum of the current plan design (\$150) or the amount of any available manufacturer-funded copay assistance.</p>		Not covered	<p>Specialty medications: 30-day fills of specialty medications must be filled using Accredo, the Express Scripts home delivery specialty pharmacy.</p> <p>Please see the “Important Questions” section (page 1) of this document regarding the plan’s out-of-pocket limit.</p>

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.bcbsnm.com](http://www.bcbsnm.com).

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		BPP Provider (you will pay the least)	Preferred Provider	Non-Preferred Provider (you will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Requires <u>preauthorization</u> .
	Physician/surgeon fees	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	

\* For more information about limitations and exceptions, see the plan or policy document at [www.bcbsnm.com](http://www.bcbsnm.com).

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		BPP Provider (you will pay the least)	Preferred Provider	Non-Preferred Provider (you will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$150 <u>copay/visit</u> plus 20% <u>coinsurance</u> after BPP <u>deductible</u>	\$150 <u>copay/visit</u> plus 20% <u>coinsurance</u> after BPP <u>deductible</u>	\$150 <u>copay/visit</u> plus 20% <u>coinsurance</u> after BPP <u>deductible</u>	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u> after BPP <u>deductible</u>	20% <u>coinsurance</u> after BPP <u>deductible</u>	20% <u>coinsurance</u> after BPP <u>deductible</u>	None
	<u>Urgent care</u>	\$50 <u>copay/visit</u> ; <u>deductible</u> does not apply	\$75 <u>copay/visit</u> ; <u>deductible</u> does not apply	\$75 <u>copay/visit</u> ; <u>deductible</u> does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Requires <u>preauthorization</u> ; \$300 penalty if not <u>preauthorized</u> .
	Physician/surgeon fees	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 <u>copay/visit</u> ; <u>deductible</u> does not apply	\$50 <u>copay/visit</u> ; <u>deductible</u> does not apply	50% <u>coinsurance</u> after <u>deductible</u>	Includes office, home, outpatient, IOP services, inpatient and partial <u>hospitalization</u> . IOP, inpatient, and partial <u>hospitalization</u> require <u>preauthorization</u> ; \$300 penalty if not <u>preauthorized</u> .
	Inpatient services	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	
If you are pregnant	Office visits	\$15/\$40 <u>copay/visit</u> ; <u>deductible</u> does not apply	\$50/\$75 <u>copay/visit</u> ; <u>deductible</u> does not apply	50% <u>coinsurance</u> after <u>deductible</u>	<u>Copay</u> charged for initial visit only. <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	

\* For more information about limitations and exceptions, see the plan or policy document at [www.bcbsnm.com](http://www.bcbsnm.com).

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		BPP Provider (you will pay the least)	Preferred Provider	Non-Preferred Provider (you will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	\$40 <u>copay/visit</u> ; <u>deductible</u> does not apply	\$75 <u>copay/visit</u> ; <u>deductible</u> does not apply	50% <u>coinsurance</u> after <u>deductible</u>	Limited to 120 visits per year for non-preferred.
	<u>Rehabilitation services</u>	\$40 <u>copay/visit</u> up to \$400 annual max; <u>deductible</u> does not apply	\$40 <u>copay/visit</u> up to \$600 annual max; <u>deductible</u> does not apply	50% <u>coinsurance</u> after <u>deductible</u>	Includes physical, speech, occupational, hearing, and autism therapies (office or outpatient); limited to 60 visits per condition per year.
	<u>Habilitation services</u>	\$40 <u>copay/visit</u> up to \$400 annual max; <u>deductible</u> does not apply	\$40 <u>copay/visit</u> up to \$600 annual max; <u>deductible</u> does not apply	50% <u>coinsurance</u> after <u>deductible</u>	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Limited to 60 days per year.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u> ; <u>deductible</u> does not apply	20% <u>coinsurance</u> ; <u>deductible</u> does not apply	50% <u>coinsurance</u> after <u>deductible</u>	<u>Deductible</u> waived for BPP and Preferred <u>providers</u> .
	<u>Hospice services</u>	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None
<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.)**

- Bariatric surgery
- Cosmetic surgery
- Dental Care (Adult, routine dental)
- Homebirths
- Infertility treatment (unless for medical condition causing the infertility)
- Long-term care
- Private duty nursing
- Routine eye care (Adult)
- Routine foot care (unless you are diabetic)
- Weight loss programs

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

- Acupuncture (25 visits per year, combined with chiropractic)
- Chiropractic care (25 visits per year, combined with acupuncture)
- Coverage provided outside the United States. See [www.bcbsnm.com](http://www.bcbsnm.com)
- Hearing aids (for dependents under age 21; max \$2,200 every 3 years)
- Non-emergency care when traveling outside the U.S.

\* For more information about limitations and exceptions, see the plan or policy document at [www.bcbsnm.com](http://www.bcbsnm.com).

**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 1-888-371-1928, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](http://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](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 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 New Mexico (BCBSNM) Appeals Unit at 1-800-205-9926 or visit [www.bcbsnm.com](http://www.bcbsnm.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](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your appeal. Contact the New Mexico Superintendent of Insurance toll-free at 1-855-427-5674 or [www.osi.state.nm.us](http://www.osi.state.nm.us).

**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 1-888-371-1928.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-371-1928.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-371-1928.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-888-371-1928.

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*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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## 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 <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist copayment</u>	\$40
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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In this example, Peg would pay:

<i>Cost sharing</i>	
Deductibles	\$500
Copayments	\$80
Coinsurance	\$2,432
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,072</b>

### Managing Joe's type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist copayment</u>	\$40
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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In this example, Joe would pay:

<i>Cost sharing</i>	
Deductibles	\$0
Copayments	\$140
Coinsurance	\$330
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$530</b>

### Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist copayment</u>	\$40
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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In this example, Mia would pay:

<i>Cost sharing</i>	
Deductibles	\$500
Copayments	\$310
Coinsurance	\$218
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,028</b>





# BlueCross BlueShield of New Mexico

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 أية 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 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.
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.
日本語 Japanese	ご本人様、またはお客様の方でも、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、情報を入力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 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, éi doodago la'da biká anánilwo'ígíí, na' idílkidgo, ts'idá bee ná ahóótí'í t'áá níik'e níká a'doolwol. Ata' halne'í bich'í' hadeesdzih ninizingo éi kwe'é da'iniishgi áká anidaalwo'ígíí bich'í' hodiilnih, bee nééhózinii bine'déé' bikáá'. Kojí atah naaltsoos ná hadít'éégóó éi doodago bee nééhózinígíí ádingo kojí' hodiilnih 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.
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 serbisyong 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
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>