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 1-855-258-3489 or visit www.bcbsmt.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 or call 1-855-258-3489 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	Tier 1 - Blue Options: \$1,100 Individual / \$2,200 Family Tier 2 - Blue Preferred: \$3,000 Individual / \$6,000 Family Tier 3 - Out-of-Network: \$5,000 Individual / \$10,000 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. 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. <u>Prescription drugs</u> , services that charge a <u>copay</u> , hospice, well-child, and Tier 1 and Tier 2 <u>preventive</u> health 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 <u>www.healthcare.gov/coverage/preventive-care-benefits/</u> .
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-</u> <u>pocket limit</u> for this <u>plan</u> ?	Tier 1 - Blue Options: \$2,200 Individual / \$4,400 Family Tier 2 - Blue Preferred: \$5,000 Individual / \$10,000 Family Tier 3 - Out-of-Network: \$6,000 Individual / \$12,000 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.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-</u> pocket limit.
Will you pay less if you use a <u>network provider</u> ?	Yes. See <u>www.bcbsmt.com</u> or call 1-855-258-3489 for a list of participating <u>providers</u> .	You pay the least if you use a <u>provider</u> in Blue Options <u>network</u> . You pay more if you use a <u>provider</u> in Tier 2 <u>network</u> . You will pay the most if you use an <u>out-of-network 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 <u>out-of- network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the specialist you choose without a referral.

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

			What You Will Pay		
Common Medical Event	Services You May Need	Tier 1 <u>Provider</u> (You will pay the least)	Tier 2 <u>Provider</u>	Tier 3 <u>Provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	\$30 <u>copay</u> /visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	50% coinsurance	Virtual visits are available through MDLive. Refer to your <u>plan</u> policy for more details.
	<u>Specialist</u> visit	10% coinsurance	30% <u>coinsurance</u>	50% coinsurance	None
If you visit a health care <u>provider's</u> office or clinic	Preventive care/screening/ immunization	No Charge; <u>deductible</u> does not apply	No Charge; <u>deductible</u> does not apply	50% <u>coinsurance</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. <u>Deductible</u> does not apply to the first \$70 for routine mammograms Out-of-Network (Tier 3).
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None

			Limitations, Exceptions, &		
Common Medical Event	Services You May Need	Tier 1 <u>Provider</u> (You will pay the least)	Tier 2 <u>Provider</u>	Tier 3 <u>Provider</u> (You will pay the most)	Other Important Information
If you need drugs to treat your illness or condition More information about <u>prescription</u> <u>drug coverage</u> is available at <u>www.bcbsmt.com/m</u> <u>ember/prescription- drug-plan- information/drug- lists</u> .	Preferred generic drugs	Value Retail: \$0 <u>copay</u> Participating Retail: \$5 <u>copay</u> Mail: \$0 <u>copay</u> ; <u>deductible</u> does not apply	Value Retail: \$0 <u>copay</u> Participating Retail: \$5 <u>copay</u> Mail: \$0 <u>copay</u> ; <u>deductible</u> does not apply	Retail: \$5 <u>copay;</u> <u>deductible</u> does not apply	Lower <u>copayment</u> applies at
	Non-preferred generic drugs	Value Retail: \$10 <u>copay</u> Participating Retail: \$15 <u>copay</u> Mail: \$20 <u>copay;</u> <u>deductible</u> does not apply	Value Retail: \$10 <u>copay</u> Participating Retail: \$15 <u>copay</u> Mail: \$20 <u>copay;</u> <u>deductible</u> does not apply	Retail: \$15 <u>copay;</u> <u>deductible</u> does not apply	Value Participating pharmacies. Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription at a plan approved mail order
	Preferred brand drugs	Value Retail: \$50 <u>copay</u> Participating Retail: \$60 <u>copay</u> Mail: \$100 <u>copay</u> ; <u>deductible</u> does not apply	Value Retail: \$50 <u>copay</u> Participating Retail: \$60 <u>copay</u> Mail: \$100 <u>copay</u> ; <u>deductible</u> does not apply	Retail: \$60 <u>copay;</u> <u>deductible</u> does not apply	pharmacy); 90-day supply (retail extended supply network pharmacy). Extended Supply Network <u>copayments</u> are three times
	Non-preferred brand drugs	Value Retail: \$100 <u>copay</u> Participating Retail: \$110 <u>copay</u> Mail: \$200 <u>copay</u> ; <u>deductible</u> does not apply	Value Retail: \$100 <u>copay</u> Participating Retail: \$110 <u>copay</u> Mail: \$200 <u>copay</u> ; <u>deductible</u> does not apply	Retail: \$110 <u>copay;</u> <u>deductible</u> does not apply	retail <u>copayments</u> . <u>Specialty drugs</u> covered up to a 30-day supply. Mail order is not covered.
	Specialty drugs	\$150 <u>copay;</u> <u>deductible</u> does not apply	\$150 <u>copay;</u> <u>deductible</u> does not apply	50% coinsurance	
If you have	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	50% coinsurance	Preauthorization required.
outpatient surgery	Physician/surgeon fees	10% coinsurance	30% coinsurance	50% coinsurance	None

* For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.bcbsmt.com</u>

0	Services You May Need		Limitations Exceptions 0		
Common Medical Event		Tier 1 <u>Provider</u> (You will pay the least)	Tier 2 <u>Provider</u>	Tier 3 <u>Provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	Emergency room care	10% <u>coinsurance</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Tier 1 & Tier 2 accident injury care is No Charge, <u>deductible</u> waived, for the first \$300 charges. Non-emergency use of the ER is subject to applicable <u>coinsurance</u> for each <u>Provider</u> Tier.
	Emergency medical transportation	10% <u>coinsurance</u>	10% <u>coinsurance</u>	10% coinsurance	None
	Urgent care	10% coinsurance	30% <u>coinsurance</u>	50% coinsurance	None
If you have a	Facility fee (e.g., hospital room)	10% coinsurance	30% <u>coinsurance</u>	50% coinsurance	Preauthorization required.
hospital stay	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse	Outpatient services	\$30 <u>copay</u> /visit; <u>deductible</u> does not apply	30% coinsurance	50% coinsurance	Preauthorization required for certain services. Virtual visits are available through MDLive. Refer to your <u>plan</u> policy for more details.
services	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% coinsurance	Preauthorization required.
lf you are pregnant	Office visits	\$30 <u>copay</u> /visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive</u> services. Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% coinsurance	50% coinsurance	<u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	10% coinsurance	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None

			What You Will Pay		
Common Medical Event	Services You May Need	Tier 1 <u>Provider</u> (You will pay the least)	Tier 2 <u>Provider</u>	Tier 3 <u>Provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Home health care	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	180 visit maximum per benefit period.
If you need help recovering or have other special health needs	Rehabilitation services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	35 visit maximum per benefit period for chiropractic care. Chiropractic care processes at Tier 1 benefit level, regardless of provider status.
	Habilitation services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	No Applied Behavior Analysis (ABA) benefits for Autism Spectrum Disorder available for members 19 years of age or older.
	Skilled nursing care	10% <u>coinsurance</u>	30% coinsurance	50% coinsurance	60 days maximum per benefit period.
	Durable medical equipment	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Hospice services	No Charge; <u>deductible</u> does not apply	No Charge; <u>deductible</u> does not apply	No Charge; <u>deductible</u> does not apply	None
If your child needs dental or eye care	Children's eye exam	No Charge; <u>deductible</u> does not apply	No Charge; <u>deductible</u> does not apply	No Charge; <u>deductible</u> does not apply	Benefit for exam: \$100 maximum per benefit period Limited to 1 exam per benefit period.
	Children's glasses	No Charge; <u>deductible</u> does not apply	No Charge; <u>deductible</u> does not apply	No Charge; <u>deductible</u> does not apply	Benefit for frames, lenses and contacts: \$150 maximum per benefit period.
	Children's dental check-up	Not Covered	Not Covered	Not Covered	None

* For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.bcbsmt.com</u>

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Ch	eck your policy or <u>plan</u> document for more	e information and a list of any other <u>excluded services</u> .)			
Bariatric surgery	Hearing aids	Long-term care			
Cosmetic surgery	Infertility treatment	Routine foot care			
Dental care (Adult)					
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)					
• Acupuncture (6 visit maximum per benefit period)	Non-emergency care when traveling	Private-duty nursing			
• Chiropractic care (35 visit maximum per benefit	outside the U.S.	 Weight loss programs (physician-led weight management 			
period)	 Routine eye care (Adult) 	programs are covered if pre-approved by the plan)			

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the <u>plan</u> at 1-855-258-3489, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <u>www.dol.gov/ebsa/healthreform</u>, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <u>www.cciio.cms.gov</u>. Other coverage options may be available to you too, including buying individual insurance coverage through the <u>Health Insurance</u> <u>Marketplace</u>. For more information about the <u>Marketplace</u>, visit <u>www.HealthCare.gov</u> or call 1-800-318-2596.

Your <u>Grievance</u> and <u>Appeals</u> Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: Blue Cross and Blue Shield of Montana at 1-855-258-3489 or visit <u>www.bcbsmt.com</u>, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit <u>www.dol.gov/ebsa/healthreform</u>. Additionally, a consumer assistance program can help you file your <u>appeal</u>. Contact the Montana Consumer Assistance Program at 1-800-332-6148 or <u>www.csi.mt.gov</u>.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have <u>Minimum Essential Coverage</u> for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-258-3489. Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-258-3489. Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-258-3489. Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-258-3489.

—To see examples of how this <u>plan</u> might cover costs for a sample medical situation, see the next section.—

About these Coverage Examples:



The total Peg would pay is

\$2,260

This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and excluded services under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

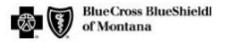
Peg is Having a Baby (9 months of in-network pre-natal ca hospital delivery)		Managing Joe's type 2 Diab (a year of routine in-network care of controlled condition)	Mia's Simple Fracture (in-network emergency room visit and follow up care)		
 The <u>plan's</u> overall <u>deductible</u> <u>Specialist coinsurance</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> 10% 		 The <u>plan's</u> overall <u>deductible</u> <u>Specialist coinsurance</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$1,100 10% 10% 10%	 The <u>plan's</u> overall <u>deductible</u> <u>Specialist coinsurance</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$1,100 10% 10% 10%
This EXAMPLE event includes service <u>Specialist</u> office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (<i>ultrasounds and blood</i> <u>Specialist</u> visit (<i>anesthesia</i>) Total Example Cost	work)	This EXAMPLE event includes service <u>Primary care physician</u> office visits (inclu- disease education) <u>Diagnostic tests</u> (blood work) <u>Prescription drugs</u> <u>Durable medical equipment</u> (glucose met	ding ter)	This EXAMPLE event includes servi <u>Emergency room care</u> (including media supplies) <u>Diagnostic test</u> (x-ray) <u>Durable medical equipment</u> (crutches) <u>Rehabilitation services</u> (physical therap	cal by)
Total Example Cost	\$12,800	Total Example Cost	\$7,400	Total Example Cost	\$1,900
In this example, Peg would pay:					
in unis example, rey would pay.		In this example, Joe would pay:		In this example, Mia would pay:	
Cost Sharing		In this example, Joe would pay: Cost Sharing		In this example, Mia would pay: Cost Sharing	
	\$1,100		\$1,100		\$1,100
Cost Sharing	\$1,100 \$0	Cost Sharing	\$1,100 \$900	Cost Sharing	\$1,100 \$0
Cost Sharing Deductibles		Cost Sharing Deductibles		Cost Sharing Deductibles	
Cost Sharing Deductibles Copayments	\$0	Cost Sharing Deductibles Copayments	\$900	Cost Sharing Deductibles Copayments	\$0

The total Joe would pay is

\$1,180

The total Mia would pay is

\$2,160



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	إن كان لديك أو لدى شخص تساعده أسللة، فلديك الحق في الحصول على المساعدة والمطومات الضرورية بلغتك من دون اية تكلفة للتحدث إلى مترجم فورى، اتصل على رقم خدمة العملاء المذكور على ظهر بطاقة عضويتك. فإن لم تكن عضوًا، أو
Arabic	كتَ لا تَبَلَكُ بِبَلَعَة. فَتَسَلَّ عَلَى 6984-710-855.
မွနျမာ Burmese	သင် သို့မဟုတ် သင်ကူညီပေးနေသူတဦးမှ မေးမြန်းလိုသည့် မေးရွန်းများရှိပါက သင့် ဘာသာစကားဖြင့် အကူအညီနှင့် အချက်အလက်များကို အခမဲ့ဖြင့်ရယူနိုင်သည့်အရွင့်အရေးရှိပါသ ည်။ ဘာသာစကား ပြန်ဆိုသူနှင့် စကားပြောရန် သင့် အဖွဲ့ ပင်ကဒ်၏ နောက်ကျောဖက်ပေါ်ရှိ သုံးစွဲသူ ပန်ဆောင်မှု ဖုန်းနံပါတ်သို့ ခေါ်ဆိုပါ။ အကယ်၍ သင်သည် အဖွဲ့ ပင်တစ်ဦး မဟုတ်ခဲ့ပါက သို့မဟုတ် ကဒ် မရှိပါက 855- 710-6984 သို့ ခေါ်ဆိုပါ။
GWV	ħ.ƏZ, D& YGT Ө .Ə&SP&EY, &&C&&&& A.B C& O&Y RCP&S3A D& RCZ4A CU COħ.Ə&A EW®Y D4V"V". O&YZ DAPA&Y C&L&ZPAT, ФЪ.ƏBW&B O&YOT O'ħG&Y
Cherokee	DOL&SP&Y O&Y PT CVP &A& DIħ&A SA.93T A4&A. АРӨ ħ₽RӨ .&Y, D& DIħ&A ħC®O .&Y, Ф&BW&S D&ħ 855-710-6984.
繁體中文	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
Chinese	會員卡,請致電 855-710-6984。
Français	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 interprête, composez le numéro du service
French	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	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
Hmong	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	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
Korean	번호로 전화하십시오. 회원이 아니시거나 카드가 없으시면 855-710-6984 으로 전화주십시오.
ພາສາລາວ	ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກ່າລັງໃຫ້ການຊ່ວຍເຫຼືອມີຄຳຖາມ. ທ່ານມີສິດຂໍເອົາການຊ່ວຍເຫຼືອ ແລະ ຂໍມູນເປັນນພາສາຂອງທ່ານໄດ້ໂດຍບໍ່ມີຄ່າ
Laotian	ໃຊ້ຈ່າຍ. ເພື່ອລົມກັບນາຍແປພາສາ, ໃຫ້ໂທຫາເບີຝ່າຍບໍລິການລູກຄ້າທີ່ມີຢູ່ດ້ານຫຼັງບັດສະມາຊິກຂອງທ່ານ. ຖ້າທ່ານບໍ່ແມ່ນສະມາຊິກ, ຫຼື ບໍ່ມີບັດ, ໃຫ້ໂທຫາເບີ 855-710-6984.
Diné Navajo	T'áá ni, čí doodago la'da bíká anánílwo'ígií, na'ídilkidgo, ts'ídá bee ná ahóóti'i' t'áá níik'e niká a'doolwol. Ata' halne'í bich'i' hadeesdzih nínízingo čí kwe'č da'íniishgi áká anídaalwo'ígií bich'i' hodíilnih, bee něčhôzinii bine'déé' bikáá'. Kojí atah naaltsoos ná hadít'čégóó čí doodago bee nčéhôzinígií ádingo koji' hodíilnih 855-710-6984.
فارسی	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 گفتگر با یک مترجم شفاهی، با خدمات مشتری به شماره ای که در پشت کارت عضویت شما
Persian	درج شده است تماس بگیرید. اگر عضو نیستید، یا کارت عضویت ندارید، با شماره 4850-710-685 تماس حاصل نمایید.
Español	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 comuniquese con el número del Servicio al
Spanish	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	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,
Tagalog	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.
ใทย	หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีข้อสงสัยใด ๆ คุณมีสิทธิที่จะได้รับความช่วยเหลือ และข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย
Thai	พูดคุยกับล่ามโดยติดต่อฝ่ายบริการลูกค้าที่หมายเลขตามที่ระบุด้านหลังบัตรสมาชิก หากไม่ใช่สมาชิกหรือไม่มีบัตร กรุณาติดต่อที่หมายเลข 855-710-6984
ار دو	گر آپ کرہ یا کسی ایسے فرد کو جس کی آپ مدد کر رہے ہیں، کوئی سوال درپیش ہے تو ، آپ کو اپنی زبان میں منت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، کسٹمر سروس نمبر اپر کال کریں جو آپ کے
Urdu	کارڈ کی پشت پر درج ہے۔ اگر آپ ممبر نہیں ہیں، یا آپ کے پاس کارڈ نہیں ہے تو ، 10-6964 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 phi. Để nói chuyện với thông dịch viên, gọi số dịch vụ khách hàng nằm ở phía sau thể hội viên của quý vị. Nếu quý vị không phải là hội viên hoặc không có thể, gọi số 855-710-6984.

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n assistance free of charg	ge, please call us at 855-710-6984.
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Phone:	855-664-7270 (voicemail) 855-661-6965
Fax:	855-661-6960
Email:	CivilRightsCoordinator@hcsc.net
artment of Health and Hu	uman Services, Office for Civil Rights, at:
Phone:	800-368-1019
	800-537-7697 thttps://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms	: http://www.hhs.gov/ocr/office/file/index.html
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