



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 [www.bcbsil.com/member/policy-forms/2022](http://www.bcbsil.com/member/policy-forms/2022) or by calling 1-800-541-2768. 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 <https://www.healthcare.gov/sbc-glossary/> or call 1-855-756-4448 to request a copy.

| Important Questions                                                | Answers                                                                                                                                                                                            | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall deductible?</b>                             | Individual: In-Network \$500<br>Out-of-Network \$1,000<br>Family: In-Network \$1,500<br>Out-of-Network \$3,000                                                                                     | 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> .                                                                                                                                                               |
| <b>Are there services covered before you meet your deductible?</b> | Yes. Doesn't apply to certain <u>preventive care</u> . Copays don't count toward the <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>              | Yes. Individual:<br>In-Network \$2,500<br>Out-of-Network \$5,000<br>Family: In-Network \$7,500<br>Out-of-Network \$15,000<br>Prescription Drug expense limit:<br>\$1,000 Individual \$3,000 Family | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>What is not included in the out-of-pocket limit?</b>            | Premiums, <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> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Will you pay less if you use a network provider?</b>            | Yes. See <a href="http://www.bcbsil.com">www.bcbsil.com</a> or call <b>1-800-541-2768</b> for a list of Participating <u>Providers</u> .                                                           | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's 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 <u>provider's charge</u> 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. |
| <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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------|----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                   |                                                  | Participating Provider (You will pay the least) | Non-Participating 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 | \$30 <u>copayment</u> /visit                    | 50% <u>coinsurance</u>                             | Virtual visits may be available, please refer to your policy for more details.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                                                   | Specialist visit                                 | \$30 <u>copayment</u> /visit                    | 50% <u>coinsurance</u>                             | none                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                                                                                                                   | Preventive care/ <u>screening</u> /immunization  | No Charge                                       | 50% <u>coinsurance</u>                             | You may have to pay for services that aren't <u>preventive</u> . Ask your provider if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>If you have a test</b>                                                                                                                                                                                                                                                                                         | Diagnostic test (x-ray, blood work)              | \$30 <u>copayment</u> /visit                    | 50% <u>coinsurance</u>                             | none                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                                                                                                                   | Imaging (CT/PET scans, MRIs)                     | 20% <u>coinsurance</u>                          | 50% <u>coinsurance</u>                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <b>prescription drug coverage</b> is available at <a href="https://www.bcbsil.com/member/prescription-drug-plan-information/drug-lists">https://www.bcbsil.com/member/prescription-drug-plan-information/drug-lists</a> | Generic drugs                                    | \$10/\$15 <u>copayment</u> /prescription        | \$15 <u>copayment</u> /prescription                | Lower <u>Copayment</u> applies to preferred participating pharmacies. Retail limited to 30 day supply. Mail order limited to 90 day supply at 2X <u>copayment</u> amount. Mail order limited to 90 day supply at 2X <u>copayment</u> amount. Certain women's preventative services will be covered with no cost to the member. For a full list of these prescriptions and/or services, please contact Customer Service. For Non-Participating drug <u>Provider</u> you are responsible for 25% of the eligible amount after the copay. Payment of the difference between the cost of a brand name drug and a generic may also be required if a generic drug is available. Specialty retail/home delivery limited to a 30 day supply. RX Out-of-Pocket Expense Limit: \$1,000 Individual/\$3,000 Family. |
|                                                                                                                                                                                                                                                                                                                   | Preferred brand drugs                            | \$40/\$50 <u>copayment</u> /prescription        | \$50 <u>copayment</u> /prescription                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                                                                                                                   | Non-preferred brand drugs                        | \$60/\$70 <u>copayment</u> /prescription        | \$70 <u>copayment</u> /prescription                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                                                                                                                   | <u>Specialty drugs</u>                           | Covered                                         | Covered                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>If you have outpatient surgery</b>                                                                                                                                                                                                                                                                             | Facility fee (e.g., ambulatory surgery center)   | 20% <u>coinsurance</u>                          | 50% <u>coinsurance</u>                             | none                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                                                                                                                   | Physician/surgeon fees                           | 20% <u>coinsurance</u>                          | 50% <u>coinsurance</u>                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |

| Common Medical Event                                                      | Services You May Need                     | What You Will Pay                                                                              |                                                           | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                           |
|---------------------------------------------------------------------------|-------------------------------------------|------------------------------------------------------------------------------------------------|-----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                           | Participating Provider (You will pay the least)                                                | Non-Participating Provider (You will pay the most)        |                                                                                                                                                                                                                                                                                                                                  |
| If you need immediate medical attention                                   | <u>Emergency room care</u>                | \$150 <u>copayment</u> /visit plus 20% <u>coinsurance</u>                                      | \$150 <u>copayment</u> /visit plus 20% <u>coinsurance</u> | <u>copayment</u> waived if admitted.                                                                                                                                                                                                                                                                                             |
|                                                                           | <u>Emergency medical transportation</u>   | 20% <u>coinsurance</u>                                                                         | 20% <u>coinsurance</u>                                    | none                                                                                                                                                                                                                                                                                                                             |
|                                                                           | <u>Urgent care</u>                        | 20% <u>coinsurance</u>                                                                         | 50% <u>coinsurance</u>                                    | <u>copayment</u> may apply.                                                                                                                                                                                                                                                                                                      |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)        | 20% <u>coinsurance</u>                                                                         | \$300 <u>copayment</u> /visit plus 50% <u>coinsurance</u> | none                                                                                                                                                                                                                                                                                                                             |
|                                                                           | Physician/surgeon fees                    | 20% <u>coinsurance</u>                                                                         | 50% <u>coinsurance</u>                                    |                                                                                                                                                                                                                                                                                                                                  |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | \$30 <u>copayment</u> for office visit or 20% <u>coinsurance</u> for other outpatient services | 50% <u>coinsurance</u>                                    | <u>Preauthorization</u> is required for Psychological testing; Neuropsychological testing; Electroconvulsive therapy; Repetitive Transcranial magnetic Stimulation; and Intensive Outpatient Treatment. Virtual visits may be available for Outpatient services, please refer to your policy for more details.                   |
|                                                                           | Inpatient services                        | 20% <u>coinsurance</u>                                                                         | \$300 <u>copayment</u> /visit plus 50% <u>coinsurance</u> |                                                                                                                                                                                                                                                                                                                                  |
| If you are pregnant                                                       | Office visits                             | \$30 <u>copayment</u>                                                                          | 50% <u>coinsurance</u>                                    | <u>Copayment</u> applies to first prenatal visit per pregnancy. <u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, <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>                                                                         | 50% <u>coinsurance</u>                                    |                                                                                                                                                                                                                                                                                                                                  |
|                                                                           | Childbirth/delivery facility services     | 20% <u>coinsurance</u>                                                                         | \$300 <u>copayment</u> /visit plus 50% <u>coinsurance</u> | none                                                                                                                                                                                                                                                                                                                             |
| If you need help recovering or have other special health needs            | <u>Home health care</u>                   | 20% <u>coinsurance</u>                                                                         | 50% <u>coinsurance</u>                                    | none                                                                                                                                                                                                                                                                                                                             |
|                                                                           | <u>Rehabilitation services</u>            | 20% <u>coinsurance</u>                                                                         | 50% <u>coinsurance</u>                                    |                                                                                                                                                                                                                                                                                                                                  |
|                                                                           | <u>Habilitation services</u>              | 20% <u>coinsurance</u>                                                                         | 50% <u>coinsurance</u>                                    |                                                                                                                                                                                                                                                                                                                                  |
|                                                                           | <u>Skilled nursing care</u>               | 20% <u>coinsurance</u>                                                                         | \$300 <u>copayment</u> /visit plus 50% <u>coinsurance</u> |                                                                                                                                                                                                                                                                                                                                  |
|                                                                           | <u>Durable medical equipment</u>          | 20% <u>coinsurance</u>                                                                         | 50% <u>coinsurance</u>                                    | Benefits are limited to items used to serve a medical purpose. <u>DME</u> benefits are provided for both purchase and rental equipment (up to the purchase price).                                                                                                                                                               |
|                                                                           | <u>Hospice services</u>                   | 20% <u>coinsurance</u>                                                                         | 50% <u>coinsurance</u>                                    | none                                                                                                                                                                                                                                                                                                                             |

| Common Medical Event                   | Services You May Need      | What You Will Pay                               |                                                    | Limitations, Exceptions, & Other Important Information |
|----------------------------------------|----------------------------|-------------------------------------------------|----------------------------------------------------|--------------------------------------------------------|
|                                        |                            | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) |                                                        |
| If your child needs dental or eye care | Children's eye exam        | Not Covered                                     | Not Covered                                        | none                                                   |
|                                        | Children's glasses         | Not Covered                                     | Not Covered                                        |                                                        |
|                                        | Children's dental check-up | Not Covered                                     | Not Covered                                        |                                                        |

#### Excluded Services & Other Covered Services:

##### Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Dental care (Adult)
- Routine eye care (Adult)
- Cosmetic surgery
- Long-term care
- Weight loss programs

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

- Bariatric surgery
- Infertility treatment (4 per benefit period)
- Private-duty nursing
- Chiropractic care (30 visit max)
- Non-emergency care when traveling outside the U.S.
- Routine foot care (Only in connection with diabetes)
- Hearing aids (for children 1 per ear every 24 months, for adults up to \$2,500 per ear every 24 months)

**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 1-800-541-2768, 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 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: Blue Cross and Blue Shield of Illinois at 1-800-541-2768 or visit [www.bcbsil.com](http://www.bcbsil.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 Illinois Department of Insurance at (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.

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-541-2768.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-541-2768.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-541-2768.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-541-2768.

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

## About These Coverage Examples:



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

### Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)

|                                   |       |
|-----------------------------------|-------|
| ■ The plan's overall deductible   | \$500 |
| ■ Specialist copayment            | \$30  |
| ■ 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

#### In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$500          |
| Copayments                        | \$400          |
| Coinsurance                       | \$1,600        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$2,560</b> |

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

|                                   |       |
|-----------------------------------|-------|
| ■ The plan's overall deductible   | \$500 |
| ■ Specialist copayment            | \$30  |
| ■ 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

#### In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$500          |
| Copayments                        | \$1,100        |
| Coinsurance                       | \$60           |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,680</b> |

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

|                                   |       |
|-----------------------------------|-------|
| ■ The plan's overall deductible   | \$500 |
| ■ Specialist copayment            | \$30  |
| ■ 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

#### In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$500          |
| Copayments                        | \$200          |
| Coinsurance                       | \$400          |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,100</b> |

The plan would be responsible for the other costs of these EXAMPLE covered services.

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 talk to an interpreter, call 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, llame al 855-710-6984.                              |
| العربية<br>Arabic        | إن كان لديك أو لدى شخص تساعد أسئلة، ف لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم فوري، اتصل بلع الرقم 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，請撥電話 號碼 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, appelez 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 Nummer 855-710-6984 an.  |
| ગુજરાતી<br>Gujarati      | જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાયદેમુબાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કોલ કરો.  |
| हिंदी<br>Hindi           | यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपके अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनवादक से बात करने के लिए 855-710-6984 पर कॉल करें।                                |
| Italiano<br>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 numero 855-710-6984.                        |
| 한국어<br>Korean            | 만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.                                                                                                                   |
| Diné<br>Navajo           | T'áá ni, éí doodago ła'da biká anánílwo'ígíí, na'ídiłkidgo, ts'ídá bee ná ahóótí'i' t'áá níik'e níká a'doolwoł dóó bina'ídiłkidígíí bee níł h odoonih. Ata'dahalne'ígíí bich'í' hodiłlnih kwe'é 855-710-6984.                 |
| فارسی<br>Persian         | اگر شما، یا کسی که شما به او کمک می کنید، سوالی 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 شماره 855-710-6984 تماس حاصل نمایید.                  |
| Polski<br>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 855-710-6984.                    |
| 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 связаться с переводчиком, позвоните по телефону 855-710-6984.     |
| Tagalog<br>Tagalog       | Kung ikaw, o ang isang taong iyong tinutulongan 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 855-710-6984. |
| اردو<br>Urdu             | اگر 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، 855-710-6984 پر کال کریں۔                                 |
| Tiếng Việt<br>Vietnamese | Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.                            |



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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>