

BLUE CROSS® AND BLUE SHIELD® OF SOUTH CAROLINA
 An Independent Licensee of the Blue Cross and Blue Shield Association
OUTLINE OF BLUECARE® COVERAGE — COVER PAGE 1 of 2:
BENEFIT PLANS A, F with High Deductible, L and N

This charts show the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state. Plans E, H, I and J are no longer available for sale after June 1, 2011.

BASIC BENEFITS:

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require you to pay a portion of Part B coinsurance or copayment.

Blood: first three pints of blood each year.

Hospice: Part A coinsurance

A	B	C	D	F	F*	G
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible		
				Part B Excess (100%)		Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency

* Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2,200 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed \$2,200. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA
 An Independent Licensee of the Blue Cross and Blue Shield Association
OUTLINE OF BLUECARE COVERAGE — COVER PAGE 2:
BENEFIT PLANS A, F with High Deductible, L and N

K	L	M	N
Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to \$20 copayment for office visit and up to \$50 copayment for emergency room
50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Foreign Travel Emergency	Foreign Travel Emergency
Out-of-pocket limit \$5,120; paid at 100% after limit reached	Out-of-pocket limit \$2,560; paid at 100% after limit reached		

PREMIUM AND RENEWABILITY INFORMATION

Your policy will stay in effect as long as you pay your premiums on time. You can choose to pay premiums monthly or every three months. Premium payments are due at the beginning of the period of time for which you are paying. You can always renew your policy at the premium rate in effect at the time of renewal. Your insurance will not lapse as long as you pay your premiums on time.

Blue Cross and Blue Shield of South Carolina can only raise your premium if we raise the premium for all policies like yours in this state. If premiums change, you will be notified at least 31 days before the change, but you will not have to pay more on a premium you have paid in advance. Note that your premium increases as you enter an older attained age group.

Age	Plan A		Plan F*		Plan L		Plan N	
	Monthly Bank Draft	Monthly	Monthly Bank Draft	Monthly	Monthly Bank Draft	Monthly	Monthly Bank Draft	Monthly
65	\$81.59	\$86.80	\$52.23	\$55.56	\$95.41	\$101.50	\$99.96	\$106.34
66	\$84.85	\$90.27	\$54.95	\$58.46	\$98.97	\$105.29	\$105.17	\$111.88
67	\$88.24	\$93.87	\$57.82	\$61.51	\$102.69	\$109.24	\$110.64	\$117.70
68	\$91.77	\$97.63	\$60.82	\$64.70	\$106.53	\$113.33	\$116.41	\$123.84
69	\$95.44	\$101.53	\$63.99	\$68.07	\$110.53	\$117.59	\$122.45	\$130.27
70	\$99.26	\$105.60	\$67.33	\$71.63	\$114.67	\$121.99	\$128.82	\$137.04
71	\$103.24	\$109.83	\$70.84	\$75.36	\$118.97	\$126.56	\$135.53	\$144.18
72	\$107.37	\$114.22	\$74.53	\$79.29	\$123.42	\$131.30	\$142.56	\$151.66
73	\$111.66	\$118.79	\$78.41	\$83.41	\$128.04	\$136.21	\$150.00	\$159.57
74	\$116.14	\$123.55	\$82.49	\$87.76	\$132.84	\$141.32	\$157.80	\$167.87
75	\$120.78	\$128.49	\$86.79	\$92.33	\$137.81	\$146.61	\$166.01	\$176.61
76	\$125.62	\$133.64	\$91.31	\$97.14	\$142.98	\$152.11	\$174.65	\$185.80
77	\$130.65	\$138.99	\$96.07	\$102.20	\$148.33	\$157.80	\$183.73	\$195.46
78	\$135.87	\$144.54	\$101.07	\$107.52	\$153.88	\$163.70	\$193.29	\$205.63
79	\$141.32	\$150.34	\$106.34	\$113.13	\$159.65	\$169.84	\$203.36	\$216.34
80+	\$146.96	\$156.34	\$111.88	\$119.02	\$165.63	\$176.20	\$213.94	\$227.60

* Rates may be reduced by 5% when at least two or more members of the same household purchase qualifying Medicare Supplement coverage through Blue Cross Blue Shield of South Carolina.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

This outline shows benefits and premiums of policies sold for an effective date on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I and J are no longer available for sale after June 1, 2011.

Read Your Policy Very Carefully

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all the rights and duties of both you and your insurance company.

Right To Return Policy

If you find that you are not satisfied with your policy, you may return it to Blue Cross and Blue Shield of South Carolina, Individual Products, Post Office Box 61153, Columbia, SC 29260-1153. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all your payments, provided you have not filed any claims.

Policy Replacement

If you are replacing another health insurance policy, DO NOT cancel it until you have actually received your new policy and are sure you want to keep it.

Notice

- This policy may not fully cover all of your medical costs.
- Neither Blue Cross and Blue Shield of South Carolina nor its agents are connected with Medicare.
- This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult the *Medicare and You* Guide for more details.

Complete Answers Are Very Important

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history (if applicable). The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

Medicare (Part A) — Hospital Services — Per Benefit Period

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but \$1,316	\$0	\$1,316 (Part A deductible)
61 st through 90 th day	All but \$329 a day	\$329 a day	\$0
91 st day and after:			
– While using 60 lifetime reserve days	All but \$658 a day	\$658 a day	\$0
Once lifetime reserve days are used:			
– Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
– Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days			
21 st through 100 th day	All approved amounts	\$0	\$0
101 st day and after	All but \$164.50 a day	\$0	Up to \$164.50 a day
	\$0	\$0	All costs
BLOOD			
First three pints	\$0	Three pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any differences between its billed charges and the amount Medicare would have paid.

Medicare (Part B) — Medical Services — Per Calendar Year

* Once you have been billed \$183 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
MEDICARE EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
– First \$183 of Medicare-approved amounts*	\$0	\$0	\$183 (Part B deductible)
– Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare-approved amounts)	\$0	\$0	All costs
BLOOD			
First three pints	\$0	All costs	\$0
Next \$183 of Medicare-approved amounts*	\$0	\$0	\$183 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES			
Tests for diagnostic services	100%	\$0	\$0
MEDICARE (PART A & B)			
HOME HEALTHCARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies			
Durable medical equipment	100%	\$0	\$0
– First \$183 of Medicare-approved amounts*	\$0	\$0	\$183 (Part B deductible)
– Remainder of Medicare-approved amounts	80%	20%	\$0

Medicare (Part A) — Hospital Services — Per Benefit Period

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2,200 deductible. Benefits from the high deductible Plan F will not begin until the out-of-pocket expenses are \$2,200. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,200 DEDUCTIBLE**, PLAN F* PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but \$1,316	\$1,316 (Part A deductible)	\$0
61 st through 90 th day	All but \$329 a day	\$329 a day	\$0
91 st day and after:			
– While using 60 lifetime reserve days	All but \$658 a day	\$658 a day	\$0
Once lifetime reserve days are used:			
– Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
		\$0	
– Beyond the additional 365 days	\$0		All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days			
21 st through 100 th day	All approved amounts	\$0	\$0
101 st day and after	All but \$164.50 a day	Up to \$164.50 a day	\$0
	\$0	\$0	All costs
BLOOD			
First three pints	\$0	Three pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any differences between its billed charges and the amount Medicare would have paid.

Medicare (Part B) — Medical Services — Per Calendar Year

* Once you have been billed \$183 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2,200 deductible. Benefits from the high deductible Plan F will not begin until the out-of-pocket expenses are \$2,200. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,200 DEDUCTIBLE**, PLAN F* PAYS	YOU PAY
MEDICARE EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
– First \$183 of Medicare-approved amounts*	\$0	\$183 (Part B deductible)	\$0
– Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare-approved amounts)	\$0	100%	\$0
BLOOD			
First three pints	\$0	All costs	\$0
Next \$183 of Medicare-approved amounts*	\$0	\$183 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES			
Tests for diagnostic services	100%	\$0	\$0
MEDICARE (PART A & B)			
HOME HEALTHCARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies			
Durable medical equipment	100%	\$0	\$0
– First \$183 of Medicare-approved amounts*	\$0	\$183 (Part B deductible)	\$0
– Remainder of Medicare-approved amounts	80%	20%	\$0
OTHER BENEFITS – Not Covered by Medicare			
FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA:			
– First \$250 each calendar year	\$0	\$0	\$250
– Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

Medicare (Part A) — Hospital Services — Per Benefit Period

* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$2,560 each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN L PAYS	YOU PAY*
HOSPITALIZATION**			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but \$1,316	\$987 (75% Part A deductible)	\$329 (25% Part A deductible) ♦
61 st through 90 th day	All but \$329 a day	\$329 a day	\$0
91 st day and after:			
– While using 60 lifetime reserve days	All but \$658 a day	\$658 a day	\$0
Once lifetime reserve days are used:			
– Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0***
– Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE**			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21 st through 100 th day	All but \$164.50 a day	Up to \$123.37 a day	Up to \$41.13 a day ♦
101 st day and after	\$0	\$0	All costs
BLOOD			
First three pints	\$0	75%	25% ♦
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	75% of Medicare copayment/coinsurance	25% of Medicare copayment/coinsurance ♦

*****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any differences between its billed charges and the amount Medicare would have paid.

Medicare (Part B) — Medical Services — Per Calendar Year

* Once you have been billed \$183 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN L PAYS	YOU PAY
MEDICARE EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
– First \$183 of Medicare-approved amounts*	\$0	\$0	\$183 (Part B deductible)* ♦
– Preventive benefits for Medicare-covered services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
– Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5% ♦
Part B Excess Charges (Above Medicare-approved amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of \$2,560)**
BLOOD			
First three pints	\$0	75%	25% ♦
Next \$183 of Medicare-approved amounts*	\$0	\$0	\$183 (Part B deductible) ♦
Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	5% ♦
CLINICAL LABORATORY SERVICES			
Tests for diagnostic services	100%	\$0	\$0

**This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$2,560 per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

MEDICARE (PART A & B)			
HOME HEALTHCARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies			
Durable medical equipment	100%	\$0	\$0
– First \$183 of Medicare-approved amounts***	\$0	\$0	\$183 (Part B deductible) ♦
– Remainder of Medicare-approved amounts	80%	15%	5% ♦

***Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

Medicare (Part A) — Hospital Services — Per Benefit Period

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but \$1,316	\$1,316 (Part A deductible)	\$0
61 st through 90 th day	All but \$329 a day	\$329 a day	\$0
91 st day and after:			
– While using 60 lifetime reserve days	All but \$658 a day	\$658 a day	\$0
Once lifetime reserve days are used:			
– Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
– Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days			
21 st through 100 th day	All approved amounts	\$0	\$0
101 st day and after	All but \$164.50 a day	Up to \$164.50 a day	\$0
	\$0	\$0	All costs
BLOOD			
First three pints	\$0	Three pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any differences between its billed charges and the amount Medicare would have paid.

Medicare (Part B) — Medical Services — Per Calendar Year

* Once you have been billed \$183 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
MEDICARE EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment: – First \$183 of Medicare-approved amounts* – Remainder of Medicare-approved amounts	\$0 Generally 80%	\$0 Balance other than up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if you are admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	\$183 (Part B deductible)* Up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if you are admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare-approved amounts)	\$0	\$0	All costs
BLOOD First three pints Next \$183 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$183 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES Tests for diagnostic services	100%	\$0	\$0
MEDICARE (PART A & B)			
HOME HEALTHCARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment – First \$183 of Medicare-approved amounts** – Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$183 (Part B deductible) \$0

**Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

OTHER BENEFITS – Not Covered by Medicare

FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA: – First \$250 each calendar year – Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
---	------------	--	---



South Carolina

*BlueCross BlueShield of South Carolina
is an independent licensee of the
Blue Cross and Blue Shield Association*

**Blue Cross® and Blue Shield® of
South Carolina**

Outline of BlueCare® Coverage

**Benefit Plans A, F with High
Deductible, L and N**

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice.

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance online at contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 1-844-396-0188]。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đỡ với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건보함에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187 로 연락주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. PC 명조 (Korean)

Kung ikaw, o ang iyong tinutulongan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839 . (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعد أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de ce plan médical, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-844-396-0190. (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره ی این برنامه ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)
