This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.ccok.com or by calling 1-877-862-1356.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$1,000 person/$2,000 family in-network; $2,000 person/4,000 family out-of-network. Doesn't apply to preventive care or pharmacy.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. In-network $3,500 person/$7,000 family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, penalties for failure to obtain pre-certification for services, health care this plan doesn't cover and out-of-network services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network providers, see www.ccok.com or call 1-877-862-1356.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services.

- Copayments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Coinsurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use in-network providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 / visit	40% co-insurance	In-network not subject to the deductible.
	Specialist visit	$50 / visit	40% co-insurance	In-network not subject to the deductible.
	Other practitioner office visit	$30 / visit	40% co-insurance	Deductible application and co-payment/co-insurance may vary based on provider type and/or place of service.
	Preventive care/ screening/ immunization	No charge	30% co-insurance	In-network not subject to the deductible.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	30% co-insurance	In-network not subject to the deductible.
	Imaging (CT/PET scans, MRIs)	20% co-insurance	40% co-insurance	Requires pre-certification. Failure to received pre-certification will result in a benefit reduction of 25% up to $1,000.00
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.ccok.com.	Preferred generic drugs	$15 Preferred retail/$20 Non-Preferred retail $30 mail order per prescription	Not covered	Covers up to a 30 day supply for retail and a 90 day supply for mail order.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Preferred brand drugs	$40 Preferred retail/$50 Non-Preferred retail $80 mail order per prescription	Not covered	Covers up to a 30 day supply for retail and a 90 day supply for mail order. The difference between brand and generic pricing is not covered.
	Non-preferred brand or generic drugs	$70 Preferred retail/$90 Non-Preferred retail $140 mail order per prescription	Not covered	Covers up to a 30 day supply for retail and a 90 day supply for mail order. The difference between brand and generic pricing is not covered.
	Specialty drugs	$160 Preferred retail/$200 Non-Preferred retail $160 mail order per prescription	Not covered	Covers up to a 30 day supply for retail and mail order. The difference between brand and generic pricing is not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250/co-payment / 20% co-insurance	$250/co-payment / 40% co-insurance	Requires pre-certification. Failure to received pre-certification will result in a benefit reduction of 25% up to $1,000.00
	Physician/surgeon fee	20% co-insurance	40% co-insurance	Requires pre-certification. Failure to received pre-certification will result in a benefit reduction of 25% up to $1,000
If you need immediate medical attention	Emergency room services	$50 / visit	$50 / visit	Benefits will be reduced by 50% if care is not deemed to be a medical emergency. Not subject to the deductible.
	Emergency medical transportation	20% co-insurance	20% co-insurance	----------none----------
	Urgent care	$50 / visit	40% co-insurance	In-network not subject to the deductible.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	$250/co-payment / 20% co-insurance	$250/co-payment / 40% co-insurance	Requires pre-certification. Failure to receive pre-certification will result in a benefit reduction of 25% up to $1,000.00
	Physician/surgeon fee	20% co-insurance	40% co-insurance	Requires pre-certification. Failure to receive pre-certification will result in a benefit reduction of 25% up to $1,000.00
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 / visit	40% co-insurance	In-network not subject to the deductible.
	Mental/Behavioral health inpatient services	$250/co-payment / 20% co-insurance	$250/co-payment / 40% co-insurance	Requires pre-certification. Failure to receive pre-certification will result in a benefit reduction of 25% up to $1,000.00
	Substance use disorder outpatient services	$30 / visit	40% co-insurance	In-network not subject to the deductible.
	Substance use disorder inpatient services	$250/co-payment / 20% co-insurance	$250/co-payment / 40% co-insurance	Requires pre-certification. Failure to receive pre-certification will result in a benefit reduction of 25% up to $1,000.00
If you are pregnant	Prenatal and postnatal care	No charge	30% co-insurance	In-network not subject to the deductible.
	Delivery and all inpatient services	$250/co-payment / 20% co-insurance	$250/co-payment / 40% co-insurance	----------none----------
If you need help recovering or have other special health needs	Home health care	20% co-insurance	40% co-insurance	Coverage limited to 60 visits annual maximum.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Rehabilitation services	20% co-insurance	40% co-insurance	Up to 60 treatment days per disability, per calendar year. Combination of physical, occupational, and speech therapy. Requires pre-certification. Failure to receive pre-certification will result in a benefit reduction of 25% up to $1,000.
	Habilitation services	Not covered	Not covered	Not covered
	Skilled nursing care	20% co-insurance	40% co-insurance	Up to 30 treatment days per disability, per calendar year. Requires pre-certification.
	Durable medical equipment	20% co-insurance	40% co-insurance	----------none----------
	Hospice service	No charge	30% co-insurance	Not subject to the deductible. Requires pre-certification. Failure to receive pre-certification will result in a benefit reduction of 25% up to $1,000.00
If your child needs dental or eye care	Eye Exam	No charge	30% co-insurance	Coverage is limited to one exam in 365 days. In-network not subject to deductible.
	Glasses	Not covered	Not covered	Not covered
	Dental check-up	Not covered	Not covered	Not covered

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child)
- Glasses
- Habilitation services
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Chiropractic Care
- Hearing aids (Limited to one for each hearing impaired ear in any 48 month period.)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-877-862-1356. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: CommunityCare at 1-877-862-1356. You may also contact the Department of Labor's Employee Benefits Security Admnistration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the Oklahoma Insurance Department at 1-800-522-0071.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". This plan or policy does provide minimum essential coverage.

Does this Coverage Provide Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Spanish (Espanol): Para obtener asistencia en Espanol, llame al 1-877-862-1356.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan Pays:** $4,056
- **Patient Pays:** $3,484

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	$7,540

Patient pays:

Deductibles	$1,900
Copays	$570
Coinsurance	$1,014
Limits or exclusions	$0
Total	$3,484

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan Pays:** $3,230
- **Patient Pays:** $2,170

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	$5,400

Patient pays:

Deductibles	$1,000
Copays	$1,110
Coinsurance	$60
Limits or exclusions	$0
Total	$2,170

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

CommunityCare

Multi-Language Interpreter Services – Taglines for Notices

Language	Translated Taglines
Spanish	Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de CommunityCare. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 1-800-777-4890.
Vietnamese	Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng bàn về đơn nộp hoặc hợp đồng bảo hiểm qua chương trình CommunityCare. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ trúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 1-800-777-4890.
Chinese	本通知有重要的訊息。本通知有關於您透過[插入 SBM 項目的名稱 CommunityCare 提交的申請或 保險的重要訊息。請留意本通知內的重要日期。 您可能需要在截止日期之前採取行動，以保留您的健康保險 或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 [在此插入数字1-800-777-4890
Korean	본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 CommunityCare 을 통한 커버리지 에 관한 정보를 포함하고 있습니다. 본 통지서에서 핵심이 되는 날짜들을 찾으십시오. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 1-800-777-4890로 전화하십시오.
German	Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch CommunityCare. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 1-800-777-4890.
Arabic	يحوي هذا الاشعار معلومات هامة. يحوي هذا الاشعار معلومات مهمة بخصوص طلبك للحصول على التغطية من خلال CommunityCare. ابحث عن التواريخ الهامة في هذا الاشعار. قد تحتاج لاتخاذ اجراء في تواريخ معينة للحفاظ على تغطيتك الصحية او للمساعدة في دفع التكاليف. لك الحق في الحصور على المعلومات والمساعدة بلغتك من دون أي تكلفة. اتصل بـ 1-800-777-4890
Burmese	ဤစာရွက်စာတမ်းတွင် အရေးကြီးသော အချက်အလက်များ ပါဝင်ပါသည်။ ဤစာရွက်စာတမ်းသည် သင်၏လျှောက်လွှာ သို့မဟုတ် CommunityCare မှတဆင့် သင်ရရှိသော အကျိုးခံစားခွင့် အချက်အလက်များ ပါဝင်ပါသည်။ အဓိကရက်စွဲများကို ဤစာရွက်စာတမ်းတွင် ရှာဖွေပါ။ သတ်မှတ်ထားသော နောက်ဆုံးရက် မတိုင်မီ ကျန်းမာရေးခံစားခွင့် သို့မဟုတ် ဈေးတွက်ခံစားခွင့် ဆက်လက်ရရှိနေစေရန် ဆောင်ရွက်ရန်လိုအပ်သည်ဟု ခံစားရပါက ဤကိစ္စနှင့်ပတ်သက်၍ မှန်ကန်သောအချက်အလက်များရရှိရန် ကုန်စရိတ် ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီရယူနိုင်ပါသည်။ 1-800-777-4890။

CommunityCare

Multi-Language Interpreter Services – Taglines for Notices

Language	Translated Taglines
Hmong	**Tsab ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb.** Tsab ntawv tshaj xo no muaj cov ntsiab lus tseem ceeb txog koj daim ntawv thov kev pab los yog koj qhov kev pab cuam los ntawm CommunityCare. Saib cov caij nyoog los yog tej hnub tseem ceeb uas sau rau hauv daim ntawv no kom zoo. Tej zaum koj kuj yuav tau ua qee yam uas peb kom koj ua tsis pub dhau cov caij nyoog uas teev tseg rau hauv daim ntawv no mas koj thiaj yuav tau txais kev pab cuam kho mob los yog kev pab them tej nqi kho mob ntawd. Koj muaj cai kom lawv muab cov ntshiab lus no uas tau muab sau ua koj hom lus pub dawb rau koj. Hu rau 1-800-777-4890.
Tagalog	Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng CommunityCare. Tingnan ang mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa 1-800-777-4890.
French	Cet avis a d'importantes informations. Cet avis a d'importantes informations sur votre demande ou la couverture par l'intermédiaire de CommunityCare. Rechercher les dates clés dans le présent avis. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez 1-800-777-4890.
Laotian	ການແຈ້ງການນີ້ມີຂໍ້ມູນສຳຄັນ. ການແຈ້ງການນີ້ມີຂໍ້ມູນທີ່ສຳຄັນກ່ຽວກັບຄຳຮ້ອງສະ ໝັກຫຼືການຄຸ້ມຄອງຂອງທ່ານໂດຍຜ່ານ CommunityCare. ເບິ່ງສ່ວນການ໌ດວັນທີ່ສຳຄັນໃນແຈ້ງການນີ້. ທ່ານອາດຈຳເປັນຕ້ອງໃຊ້ເວລາດຳເນີນການໂດຍການ໌ດເວລາທີ່ແນ່ນອນ ຈະຮັກສາການຄຸ້ມຄອງສຸຂະພາບຂອງທ່ານຫຼືການຊ່ວຍເຫຼືອທີ່ມີຄ່າໃຊ້ຈ່າຍ. ທ່ານມີສິດທີ່ຈະໄດ້ຮັບຂໍ້ມູນຂ່າວສານນີ້ແລະການຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານທີ່ບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ໂທ 1-800-777-4890.
Thai	ประกาศนี้มีข้อมูลสำคัญ ประกาศนี้มีข้อมูลที่สำคัญเกี่ยวกับการการสมัครหรือรอบเรตประกันสุขภาพของคุณผ่าน CommunityCare ดูกำหนดการในประกาศนี้ คุณอาจจะต้องดำเนินการภายในกำหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่าย คุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือนี้ในภาษาของคุณโดยไม่มีค่าใช้จ่าย โทร 1-800-777-4890
Urdu	اس اشتہار میں اہم معلومات ہے۔ اس اشتہار میں CommunityCare سے اپ کے درخواست اور خدمات کے بارے میں اہم معلومات ہے۔اشتہار میں اہم تاریخوں کا نظر کریں۔ ہو سکتا ہے کی صحت کی خدمات کو برقرار رکھنے اور اخراجات کی ادائگی میں مالی مدد ملنے کے لیے، اپ کو خاص تاریخ یا ٹیڈ لائن سے پہلے کچھ کارروائی کرنی پڑے گی۔ اپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ 1-800-777-4890 فون کریں۔
Cherokee	ᎤᎳᏫᏁᏗ ᏚᎩᏃᏢᎢ ᎤᏁᏫᏁᏗ. ᏭᎠ ᎤᎳᏫᏁᏗ RGZᏭ4 ᏂᎶᎳᏒᏝᎢ RGᏋᏫᏫᏙᏗ ᎤᏂᏫᎪᎳᏫᏍ ᏭᎴhᏙᏊ RGᏚ4ᏫᏫᏍᏯ CommunityCare ᏚᎶᎾᏫᏫᏓᏁᏅᎢ. ᏣᏚᎶᏫᏚᏫᏗ ᏮᏙᏫᏢR ᏭᎠ ᏚᎩᏃᏢᎢ. RMᏫ ᎪᎢᏫᏗ ᏦᏭᎶᏗ DᏪ ᏳᏫᏁᏃ ᏯhEᎳᏫᏓ ᎤᏫᏭB TS ᏂᏚᎪᏭᏊ. ᏙᏭ ᏳᏚᏃ DhDᏪᏯᏫᏚ GᏫᐯ DᏪ ᏧEGᎳᏫᎢ ᏲR ᎤᏁᏣᏫᏗ hᏲRᎾ GᏰᎳᏗ. DᏓᏫAᎳᏫᏯ DᏓᏫᏚᎳᏗ RGᏁᏗ ZᏪ RGZᏭ4Ꮓ ᏀᏚᏫᏋ ᏀᏚᎳhᏋᏫᏗᏯ ᏀᏙᏢ ᏚᏫhᏭᏫᏗ EᏃ ZᏪ ᏧEGᎳᏗ hᏲRᎾ ᏲRT. ᏗᎳZᏢᏗ Ꮧ4ᏫᏗ ᏭD 1-800-777-4890.
Persian-Farsi	ن اع‌الم‌ي‌ه ح‌اوی ا ال‌ع‌ات م‌ه‌م‌ش‌ان اين اع‌الم‌ي‌ه ح‌اوی ا ال‌ع‌ام‌ه‌م درب‌اره وم تق‌اض‌ا‌ي‌ا ب‌ي‌م‌ه‌ش‌وش‌ه‌ي‌ه ای ش‌ما رو ب‌ه وط‌ب‌ه CommunityCare ب‌ه‌ت‌اري‌خ ه‌ای م‌ه‌م در ای‌ن اع‌الم‌ي‌ه‌ت‌وج‌ه ش‌ود. ش‌ما ب‌ای‌د ب‌ه‌ت‌اري‌خ ه‌ای ح‌ق‌ب‌ه‌ش‌ر‌ای ح‌ف‌ظ ب‌ه‌ش‌ر‌ای ا‌ی‌ا ر‌ای ک‌م‌ک‌ب‌ه خ‌ارج ز‌ب‌ان ا‌ی‌ن ا ال‌ع‌ات و ک‌م‌ک ب‌ه‌ای ف‌ز‌وب‌ه‌ان‌ج‌ام ک‌ار‌ه‌ای‌ی‌ش‌ان ا‌ی‌ن ح‌ق‌ا ش‌ما ب‌ای‌د. ر‌ای‌گ‌ان ط‌ور ا‌ی‌ن ح‌ق‌ا ش‌ما ب‌ای‌د ر‌ی‌اف‌ت ن‌م‌ای‌ی‌د. 1-800-777-4890

CommunityCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. CommunityCare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

CommunityCare:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Mary Alice Brosseau. If you believe that CommunityCare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Mary Alice Brosseau, Senior Manager Quality Improvement/Compliance
P.O. Box 3249 Tulsa, Oklahoma 74101
(918) 594-5303 (phone)
(918) 879-4048 (fax)
G&A@ccok.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Mary Alice Brosseau, Senior Manager Quality Improvement/Compliance, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.