Coverage for: Individual or Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-888-796-0609 (TTY: 1-800-848-0299) or visit us at www.bcbst.com. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, provider, or other underlined terms see the Glossary. You can view the Glossary at <a href="https://healthcare.gov/sbc-glossary">https://healthcare.gov/sbc-glossary</a> or call 1-888-796-0609 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: \$450 person/\$1,350 family Out-of-network: \$850 person/\$2,550 family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible?</u>	Yes. <u>Preventive services</u> , Office visits, and Emergency room visits are covered before you meet your <u>deductible</u> (unless specified).	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="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In-network: \$3,000 person/\$5,000 family; Out-of-network: \$4,000 person/\$6,000 family Pharmacy (in-network only): \$3,000 person/\$5,000 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit?</u>	Premium, balance-billing charges, penalties, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.bcbst.com/network-P or call 1-888-796-0609 for a list of network providers.	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</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield Association.

Questions: Call 1-888-796-0609 or visit us at www.bcbst.com.

Important Questions	Answers	Why This Matters:
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the specialist you choose without a referral.



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

Common		What You Will Pay		Limitations, Exceptions, & Other
Medical Event	Services You May Need In-Notw		Out-of-Network Provider (You will pay the most)	Important Information
	Primary care visit to treat an injury or illness	\$15 <u>copay</u> /visit	40% coinsurance	Teladoc Health \$15 <u>copay</u> St. Jude On-site Clinic (Employee Only) - \$10 <u>copay</u> /visit
If you visit a health care <u>provider's</u> office or clinic	Specialist visit	\$25 <u>copay</u> /visit	40% coinsurance	In-Network Office surgery subject to Primary Care/Specialist copayment. Out-of-Network Office surgery subject to deductible and coinsurance.
	Preventive care/screening/ immunization	No Charge	40% coinsurance	A1c testing will be covered at 100%. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u> without associated office visit. On-Site Clinic: No Charge	40% coinsurance	Diagnostic testing benefits are determined by place of service, such as office or ER.  St. Jude On-site Clinic (Employee Only) – If filed with Office Visit, copay will apply.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u> without associated office visit.	40% coinsurance	Prior Authorization required.

Common		What You Will Pay		Limitations, Exceptions, & Other	
Medical Event Services You May Need		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information	
	Generic drugs	\$5 <u>copay</u> (retail) \$10 <u>copay</u> (mail order or Maintenance Choice retail)	Not Covered	No <u>copayment</u> applies for Generic preventive care drugs (e.g., covered tobacco cessation products or contraception).	
If you need drugs to treat your illness or condition More information about prescription drug	Preferred brand drugs	\$30 copay (retail) \$60 copay (mail order or Maintenance Choice retail)	Not Covered	If a Generic drug is available and you obtain a Preferred brand name drug instead, the Generic drug copayment above applies, plus you pay the difference in cost of the Brand name drug and the Generic drug.	
coverage is available at www.caremark.com	Non-preferred brand drugs	\$60 <u>copay</u> (retail) \$120 <u>copay</u> (mail order or Maintenance Choice retail)	Not Covered	None	
	Specialty drugs	\$75 <u>copay</u> (retail) \$150 <u>copay</u> (mail order or Maintenance Choice retail)	Not Covered	Step Therapy may apply.	
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Prior Authorization required for certain outpatient procedures.	
surgery	Physician/surgeon fees	20% coinsurance	40% coinsurance	Prior Authorization required for certain outpatient procedures.	
	Emergency room care	\$100 <u>copay</u> /visit	\$100 <u>copay</u> /visit	Copayment is waived if admitted as an inpatient, and hospital stay provisions below (including coinsurance and Prior Authorization requirement) will instead apply.	
If you need immediate medical attention	Emergency medical transportation	20% coinsurance	20% coinsurance	None	
	<u>Urgent care</u>	\$35 <u>copay</u>	40% coinsurance	None	
If you have a hospital stay	Facility fee (e.g., hospital room) Physician/surgeon fees	20% coinsurance 20% coinsurance	40% <u>coinsurance</u> 40% <u>coinsurance</u>	Prior Authorization required. Prior Authorization required.	

Common		What You Will Pay		Limitations, Exceptions, & Other	
Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 <u>copay</u> /visit <u>deductible</u> does not apply for office visits and 20% <u>coinsurance</u> other outpatient services	40% coinsurance	Prior Authorization required for other outpatient procedures.  St. Jude On-site Clinic (Employee Only) – \$0 copay/visit	
	Inpatient services	20% coinsurance	40% coinsurance	Prior Authorization required.	
	Office visits	\$15 <u>copay</u> /visit	40% coinsurance	Teladoc Health \$15 copay  In-Network Office surgery subject to Primary Care/Specialist copayment. Out-of-Network Office surgery subject to deductible and coinsurance.	
If you are pregnant	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	This service may be covered under the Specialty Care Program. Cost Share may vary; use a Blue Distinction Center for best benefit.	
				This service may be covered under the Specialty Care Program. Cost Share may vary; use a Blue Distinction Center for best benefit.	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	Prior Authorization is required for hospital stays over 48 hours for a vaginal delivery and over 96 hours for a cesarean section delivery.	
	Home health care	20% coinsurance	40% coinsurance	Prior Authorization required and may be subject to a penalty if not obtained.	
If you need help recovering or have other special health needs	Rehabilitation services	\$25 <u>copay</u> /visit	40% coinsurance	Physical, speech, occupational and spinal manipulation therapy limited to 36 visits per type per year (visit limit does not apply when therapy provided for autism diagnosis).	
	Habilitation services	\$25 <u>copay</u> /visit	40% coinsurance	Physical, speech, occupational and spinal manipulation therapy limited to 36 visits per	

Common		What You Will Pay		Limitations, Exceptions, & Other	
Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information	
				type per year (visit limit does not apply when therapy provided for autism diagnosis).	
	Skilled nursing care	20% coinsurance	40% coinsurance	Skilled nursing and rehabilitation facility limited to 120 days combined per year. Prior Authorization required and may be subject to a penalty if not obtained.	
	Durable medical equipment	No charge with office visit; 20% coinsurance without office visit.	40% coinsurance	Prior Authorization may be required for certain durable medical equipment.	
	Hospice services	20% coinsurance	40% coinsurance	Prior Authorization required for inpatient hospice.	
If your shild peeds	Children's eye exam	Not Covered	Not Covered	May be severed under congrete vision or	
If your child needs dental or eye care	Children's glasses	Not Covered	Not Covered	May be covered under separate vision or dental plan, if you have one.	
dental of eye cale	Children's dental check-up	Not Covered	Not Covered	dental plan, il you have one.	

### **Excluded Services & Other Covered Services:**

,	Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)				
•	Cosmetic surgery	•	Long-term care	•	Routine eye care (Children)
•	Dental care (Adult)	•	Non-emergency care when traveling outside the	•	Routine foot care for non-diabetics
•	Dental care (Children)		U.S.	•	Weight loss programs
		•	Routine eye care (Adult)		

Ot	Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)					
•	Acupuncture	•	Hearing aids for children under 18	•	Prescription Drugs (including weight loss drugs,	
•	Bariatric surgery	•	Infertility treatment (only if obtained through		only if obtained In-Network)	
•	Chiropractic care		Progyny)	•	Private-duty nursing	
•	Hearing aids for adults					

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:

• For plans subject to ERISA, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or BlueCross at 1-888-796-0609 or www.bcbst.com, or contact your plan administrator.

Other coverage options may be available to you too, including buying individual insurance coverage through the <u>Health Insurance Marketplace</u>. For more information about the <u>Marketplace</u>, visit <u>www.HealthCare.gov</u> or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- BlueCross at 1-888-796-0609 or <a href="https://www.bcbst.com">www.bcbst.com</a>, or your plan administrator.
- For plans subject to ERISA, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program can help you file your appeal. Contact the Tennessee Department of Commerce and Insurance (TDCI) at 1-800-342-4029, <a href="https://sbs.naic.org/solar-web/pages/public/onlineComplaintForm/onlineComplaintForm.jsf?state=tn&dswid=-8432">https://sbs.naic.org/solar-web/pages/public/onlineComplaintForm/onlineComplaintForm.jsf?state=tn&dswid=-8432</a>, or email them at CIS.Complaints@state.tn.us. You may also write them at 500 James Robertson Pkwy, Davy Crockett Tower, 6th Floor, Nashville, TN 37243.

## Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes <u>plans</u>, <u>health insurance</u> available through the <u>Marketplace</u> or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of <u>Minimum Essential Coverage</u>, you may not be eligible for the <u>premium tax credit</u>.

# Does this plan meet 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.

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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

# Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$450
Specialist copay	\$25
■ 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)

Total Example Cost	\$12,700

# In this example, Peg would pay:

Cost Sharing				
<u>Deductibles</u>	\$450			
Copayments	\$0			
Coinsurance	\$2,400			
What isn't covered				
Limits or exclusions	\$70			
The total Peg would pay is	\$2,920			

# Managing Joe's type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$450
■ Specialist copay	\$25
■ Hospital (facility) coinsurance	20%
Other coinsurance	20%

#### This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (*including disease education*)

<u>Diagnostic tests</u> (blood work)

Prescription drugs

<u>Durable medical equipment</u> (glucose meter)

|--|

# In this example, Joe would pay:

<u>Cost Sharing</u>		
<u>Deductibles</u>	\$450	
Copayments	\$90	
Coinsurance	\$700	
What isn't covered		
Limits or exclusions	\$400	
The total Joe would pay is	\$1,640	

# **Mia's Simple Fracture**

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

■ The <u>plan's</u> overall <u>deductible</u>	\$450
Specialist copay	\$25
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

#### This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (x-ray)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$2,800
•	

# In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$450
Copayments	\$300
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$10
The total Mia would pay is	\$1,060

#### BlueCross BlueShield of Tennessee

BlueCross BlueShield of Tennessee (BlueCross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex'. BlueCross does not exclude people or treat them less favorably because of race, color, national origin, age, disability or sex.

#### Rlue Cross

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as: (1) qualified sign language interpreters and (2) written information in other formats, such as large print, audio and accessible electronic formats.
- Provides free language assistance services to people whose primary language is not English, such as: (1) qualified interpreters and (2) information written in other languages.

If you need these reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact a consumer advisor at the number on the back of your Member ID card or call 1-800-565-9140 (TTY: 1-800-848-0298 or 711).

If you believe that BlueCross 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 ("Nondiscrimination Grievance"). For help with preparing and submitting your Nondiscrimination Grievance, contact a consumer advisor at the number on the back of your Member ID card or call 1-800-565-9140 (TTY: 1-800-848-0298 or 711). They can provide you with the appropriate form to use in submitting a Nondiscrimination Grievance. You can file a Nondiscrimination Grievance in person or by mail, fax or email. Address your Nondiscrimination Grievance to: Nondiscrimination Grievance, Member Benefits Administration; 1 Cameron Hill Circle, Suite 0019, Chattanooga, TN 37402-0019; (423) 591-9208 (fax); Nondiscrimination\_OfficeGM@bcbst.com (email)

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, DC 20201, 1–800–368–1019, 800–537–7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

You can contact BlueCross's Nondiscrimination Coordinator at 423-535-1010 (TTY: 1-800-848-0298 or 711); Nondiscrimination\_ CoordinatorGM@bcbst.com (email); or Corporate Compliance, 1 Cameron Hill Circle, 1.4, Chattanooga, TN 37402.

This notice is available at BlueCross's website: bcbst com

BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield Association.

BlueCross BlueShield of Tennessee is a Qualified Health Plan Issuer in the Health Insurance Marketplace.

<sup>1</sup> Consistent with the scope of sex discrimination described at 45 CFR 92.101(a)(2))

ATTENTION: If you speak English, free language assistance services and appropriate auxiliary aids and services are available to you. Please call the Member Service number on the back of your Member ID card or 1-800-565-9140 (TTY: 1-800-848-0298).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma, así como ayudas y servicios auxiliares adecuados. Llame al número de Servicio de atención a miembros que figura en el reverso de su tarjeta de identificación de miembro o al 1-800-565-9140 (TTY: 1-800-848-0298).

اتنباه: إذا كنت تتحدث العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية والخدمات والأدوات المساعدة المناسبة. يُرجي الاتصال برقم خدمة الاعضاء الموجود على ظهر بطاقة هوية العضو الخاص بك أو بالرقم على 288-808-10 (الهائف النصي: 848-848-800-1.

注意:如果您說中文,我們提供免費的語言協助服務,以及適當的輔助協助和服務。請撥打會員ID卡背面的會員服務部號碼或1-800-565-9140(聽障專線 (TTY): 1-800-848-0298)。

LƯU Ý: Nếu quý vị nói tiếng Việt, quý vị sẽ được cung cấp các dịch vụ hỗ trợ ngồn ngữ miễn phí và các dịch vụ và công cụ hỗ trợ phù hợp. Vui lòng gọi đến số của bộ phận Dịch vụ Hội viên ở mặt sau Thẻ ID Thành viên của quý vị hoặc số 1-800-565-9140 (TTY: 1-800-848-0298).

주의: [한국어]를 사용하시는 경우, 무료 언어 지원 서비스 및 적절한 보조 기구와 서비스가 제공됩니다. 가입자 ID 카드 뒷면의 가입자 서비스 전화번호 또는 1-800-565-9140(TTY: 1-800-848-0298)번으로 전화하시기 바랍니다.

ATTENTION: Si vous parlez français, des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés sont à votre disposition. Veuillez appeler le numéro du Service adhérents indiqué au dos de votre carte d'assuré adhérent ou le 1-800-565-9140 (TTY/ATS: 1-800-848-0298).

ເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າພາສາ ພາສາລາວ, ມີການບໍລິການ ຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການທີ່ ເໝາະສົມໃຫ້ທ່ານ. ກະລຸນາໂທຫາເບີຂອງຝ່າຍບໍລິການສະມາຊິກ ທີ່ມີຢູ່ດ້ານຫຼັງບັດ ID ສະມາຊິກຂອງທ່ານ ຫຼື 1-800-565-9140 (TTY: 1-800-848-0298).

ማስገንዘቢያ፦ አማርኛ የሚናገሩ ከሆነ፣ ነጻ የቋንቋ እርዳታ አገልግሎቶች እና ተገቢ ረዳት መርጃዎች እና አገልግሎቶች ለእርስዎ ይገኛሉ። በአባልነት መታወቂያዎ ጀርባ ላይ በሚገኘው የአባላት አገልግሎት ቁጥር ወይም በ 1-800-565-9140 (TTY: 1-800-848-0298) ይደውሉ።

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste und geeignete Hilfsmittel und Dienstleistungen zur Verfügung. Bitte rufen Sie die Nummer des Mitgliederdienstes auf der Rückseite Ihrer Mitglieds-ID-Karte oder 1-800-565-9140 (TTY: 1-800-848-0298) an.

ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો તમારા માટે નિ:શુલ્ક ભાષા સહાય સંવાઓ અને યોગ્ય સહાયક સાધનો અને સવાઓ ઉપલબ્ધ છે. કૃપા કરીને તમારા સભ્ય ID કાર્ડની પાછળના સભ્ય સર્વીસ નંબર ઉપર અથવા 1-800-565-9140 (TTY: 1-800-848-0298) પર કૉલ કરો.

お知らせ:日本語をお話しになる場合は、無料の支援サービスと適切な補助器具・サービスがご利用いただけます。会員IDカードの裏面に記載の会員サービス番号あるいは1-800-565-9140 (TTY: 1-800-848-0298)まで、お電話にてご連絡ください。

PANSININ: Kung kayo ay nagsasalita ng Tagalog, magagamit para sa inyo ang libreng mga serbisyong tulong sa wika at kaukulang mga karagdagang tulong at mga serbisyo. Mangyaring tawagan ang numero ng Serbisyo sa Miyembro na nasa likod ng inyong Kard ng ID ng Miyembro osa 1-800-565-9140 (TTY: 1-800-848-0298).

श्यान दें यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएँ और उपयुक्त सहायक साधन और सेवाएँ उपलब्ध हैं। कृपया अपने सदस्य ID कार्ड के पीछे दिए गए सदस्य सेवा नेवर या 1-800-565-9140 (TTY: 1-800-848-0298) पर कॉल करें। ВНИМАНИЕ! Если Вы говорите по-русски, Вам будут предоставлены услуги языковой поддержки и соответствующие вспомогательные средства и сервисы на бесплатной основе. Позвоните в отдел обслуживания участников по номеру, указанному на обратной стороне Вашей идентификационной карты участника, или по номеру 1-800-565-9140 (ТТҮ: 1-800-848-0298).

توجه: اگر به زبان فارسی صحبت می کنید، خدمات کمک زبانی رایگان و مساعدت ها و خدمات کمکی مناسب در دسترس شما هستند. درصورتیکه عضو هستید، با شماره خدمات اعضا در پشت کارت عضویت خود یا 0410-565-1880 (TTY: 1-800-848-0297) تماس ، نگیر بد.

ATANSYON: Si w pale Kreyòl Ayisyen, genyen sèvis asistans gratis pou lang ansanm ak èd pou sèvis oksilyè apwopriye k ap disponib pou ou. Tanpri rele nimewo Sèvis Manm ki sou do kat ID Manm ou an oswa 1-800-565-9140 (TTY: 1-800-848-0298).

UWAGA: Osoby posługujące się językiem polskim mogą bezpłatnie skorzystać z pomocy językowej oraz rozwiązań i usług pomocniczych. Prosimy zadzwonić pod numer działu obsługi ubezpieczonych podany na odwrocie karty identyfikacyjnej członka lub numer 1-800-565-9140 (TTY: 1-800-848-0298).

ATENÇÃO: Se você fala Português, serviços gratuitos de assistência linguística e recursos e serviços auxiliares apropriados estão disponíveis para você. Ligue para o número de telefone do serviço de Atendimento ao Membro informado no verso de seu cartão de identificação de membro ou para 1-800-565-9140 (TTY: 1-800-848-0298).

ATTENZIONE: se parla italiano, sono disponibili per Lei servizi gratuiti di assistenza linguistica nonché aiuti e servizi ausiliari adeguati. Chiami il numero del Servizio per i membri riportato sul retro della Sua scheda identificativa del membro oppure il numero 1-800-565-9140 (TTY: 1-800-848-0298).

BAA'áKOHWIINIDZIN: Diné bizaad bee yánítti'go, t'áá jilk'eh saad bee áka'aná'awo' bee áka'anída'awo'i dóó t'áadoole'é binahji' bee adahodoonítígíí diné bich'i' anídahazt'i'í bee bika'aanída'awo'i ná dahóló. T'áá shóódí Bił Ha'dít'éhí Bika'aná'awo' Bił Ha'dít'éhí ID naaltsoos nitt'izí bine'déé' binámboo bee hodíilnih doodago 1-800-565-9140 (TTY: 1-800-848-0298).

WICHDICH: Wann du Deitsch schwetzscht un brauchscht Hilf fer communicat-e kenne mer dich helfe unni as es dich ennich eppes koschde zellt. Mir kenne differnti Sadde Schprooch-Hilf beigriege aa fer nix. Ruf der Member Service Number uff die hinnerscht Seit vun dei Member ID Card uff odder 1-800-565-9140 (TTY: 1-800-848-0298).

FAASILASILAGA: Afai e te tautala i le faa-Samoa, o loo avanoa mo oe auaunaga fesoasoani mo gagana e aunoa ma se totogi faapea ma fesoasoani fa'aopo'opo ma auaunaga talafeagai. Faamolemole vala'au le numera o le Member Service (Auaunaga mo Tagata Auai) o lo'o i tua o lau pepa ID o le Member (Tagata Auai) po o le 1-800-565-9140 (TTY: 1-800-848-0298).

GAKIULA: Gare iga go kapetal Faluwasch, ye toore paliuwal yamem bwe tepangug rel gamatefal lane kapetal Faluwasch. Fale peshem kol yegili nampal Member Service ila yelog liugul tagurul Member ID kard la yam gare 1-800-565-9140 (TTY: 1-800-848-0298).

ATENSION: Guaha setbisio siha para hågu yanggen fifino' CHamoru hao, dibåtde na setbision inayudon fumino' CHamoru yan propriu na inasisten tråstes yan setbisio siha. Put fabot ågang i numiron Setbision Membro gi santatten i kattå-mu Member ID pat 1-800-565-9140 (TTY: 1-800-848-0298).