




The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-565-9140 (TTY: 1-800-848-0299) or visit us at [www.bcbst.com](http://www.bcbst.com). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-800-565-9140 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	In-network: \$5,500 person/\$11,000 family Out-of-network: \$11,000 person/\$22,000 family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your deductible?</b>	Yes. <u>Deductible</u> doesn't apply to <u>preventive care</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="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://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>	In-network: \$6,550 person/\$13,100 family Out-of-network: \$16,000 person/\$22,000 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.
<b>What is not included in the out-of-pocket limit?</b>	<u>Premium</u> , <u>balance-billing</u> charges, penalties, 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. This <u>plan</u> uses Network S. See <a href="http://www.bcbst.com/Network-S">http://www.bcbst.com/Network-S</a> or call 1-800-565-9140 for a list of <u>in-network 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.

Important Questions	Answers	Why This Matters:
Do you need a <u>referral</u> to see a <u>specialist</u> ?	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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Teladoc Health Covered at 100%
	Specialist visit	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Preventive care/screening/immunization	No Charge	50% <u>coinsurance</u>	A1c testing will be covered at 100%. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. Travel immunization not covered in office or clinic setting.
If you have a test	Diagnostic test (x-ray, blood work)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Prior Authorization required. Your cost share may increase to 60% if not obtained.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <a href="http://www.bcbst.com/rxp">www.bcbst.com/rxp</a>	Preferred Generic drugs / Non-Preferred Generic drugs	30% <u>coinsurance</u>	50% <u>coinsurance</u>	30 day supply for Retail Network; up to 90 day supply for Home Delivery or Plus90 Network
	Preferred brand drugs	30% <u>coinsurance</u>	50% <u>coinsurance</u>	30 day supply for Retail Network; up to 90 day supply for Home Delivery or Plus90 Network
	Non-preferred brand drugs	30% <u>coinsurance</u>	50% <u>coinsurance</u>	30 day supply for Retail Network; up to 90 day supply for Home Delivery or Plus90 Network
	Preferred <u>Specialty</u> drugs / Non-Preferred <u>Specialty</u> drugs	30% <u>coinsurance</u>	Not Covered	Up to a 30 day supply. Must use a pharmacy in the Preferred Specialty Pharmacy Network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 60% if not obtained. *See Prior Authorization section.
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Prior Authorization required for certain outpatient procedures. Your cost share may

\* For more information about limitations and exceptions, see the plan or policy document at <http://www.bcbst.com/samplepolicy/2026/LG.pdf>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				increase to 60% if not obtained. *See Prior Authorization section.
If you need immediate medical attention	<u>Emergency room care</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Urgent care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Prior Authorization required. Your cost share may increase to 60% if not obtained.
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Prior Authorization required. Your cost share may increase to 60% if not obtained.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 60% if not obtained. *See Prior Authorization section.
	Inpatient services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Prior Authorization required. Your cost share may increase to 60% if not obtained.
If you are pregnant	Office visits	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Cost sharing does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Childbirth/delivery facility services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need help recovering or have other special health needs	<u>Home health care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Unlimited
	<u>Rehabilitation services</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Therapy limited to 60 visits per type per year. Cardiac/Pulmonary rehab limited to 36 visits per type per year.
	<u>Habilitation services</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Therapy limited to 60 visits per type per year. Cardiac/Pulmonary rehab limited to 36 visits per type per year.
	<u>Skilled nursing care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Skilled nursing and rehabilitation facility limited to 120 days combined per year.
	<u>Durable medical equipment</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Prior Authorization may be required for certain <u>durable medical equipment</u> . Your cost share may increase to 60% if not

\* For more information about limitations and exceptions, see the plan or policy document at <http://www.bcbst.com/samplepolicy/2026/LG.pdf>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				obtained. *See Prior Authorization section.
	Hospice services	30% coinsurance	50% coinsurance	Prior Authorization required for inpatient hospice. Your cost share may increase to 60% if not obtained.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

**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.)		
<ul style="list-style-type: none"> <li>Bariatric surgery</li> <li>Cosmetic surgery</li> <li>Dental care (Adult)</li> <li>Dental care (Children)</li> <li>Hearing aids for adults</li> </ul>	<ul style="list-style-type: none"> <li>Infertility treatment</li> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> <li>Private-duty nursing</li> </ul>	<ul style="list-style-type: none"> <li>Routine eye care (Adult)</li> <li>Routine eye care (Children)</li> <li>Routine foot care for non-diabetics</li> <li>Weight loss programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> <li>Acupuncture</li> </ul>	<ul style="list-style-type: none"> <li>Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids for children under 18</li> </ul>

**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](http://www.dol.gov/ebsa/healthreform).
- For non-federal governmental plans, the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).
- For church plans, the State Division of Benefits Administration at 1-866-576-0029.
- BlueCross at 1-800-565-9140 or [www.bcbst.com](http://www.bcbst.com), or contact your plan administrator.

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 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:

\* For more information about limitations and exceptions, see the plan or policy document at <http://www.bcbst.com/samplepolicy/2026/LG.pdf>.

- BlueCross at 1-800-565-9140 or [www.bcbst.com](http://www.bcbst.com), 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](http://www.dol.gov/ebsa/healthreform).
- The State Division of Benefits Administration at 1-866-576-0029.

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, <https://sbs.naic.org/solar-web/pages/public/onlineComplaintForm/onlineComplaintForm.jsf?state=tn&dswid=-8432>, or email them at [CIS.Complaints@state.tn.us](mailto: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 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 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 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 <u>plan's</u> overall <u>deductible</u>	\$5,500
■ <u>Specialist</u> <u>coinsurance</u>	30%
■ <u>Hospital (facility)</u> <u>coinsurance</u>	30%
■ <u>Other</u> <u>coinsurance</u>	30%

#### 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:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$5,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,100
<u>What isn't covered</u>	
Limits or exclusions	\$20
<b>The total Peg would pay is</b>	<b>\$6,570</b>

### 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>	\$5,500
■ <u>Specialist</u> <u>coinsurance</u>	30%
■ <u>Hospital (facility)</u> <u>coinsurance</u>	30%
■ <u>Other</u> <u>coinsurance</u>	30%

#### 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:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$5,100
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$30
<b>The total Joe would pay is</b>	<b>\$5,130</b>

### Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$5,500
■ <u>Specialist</u> <u>coinsurance</u>	30%
■ <u>Hospital (facility)</u> <u>coinsurance</u>	30%
■ <u>Other</u> <u>coinsurance</u>	30%

#### 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:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>

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.

BlueCross:
• 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, c/o Manager-Operations, 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/ocrportal/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, 14, 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.

\* 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 call 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).

انتباه: إذا كنت تتحدث العربية، فستتاح لك خدمات المساعدة اللغوية الحاصلة والمستقلة بالواتساب المجانية.

المساعدة اللغوية الحاصلة والمستقلة بالواتساب المجانية على ظهر بطاقة الرقم الحصري للعضو (1-800-848-0298 (الرقم الهاتفي) 1-800-565-9140

注意: 如果您说中文, 我们将提供免费的语言协助服务, 以及适当的辅助协助和服務。請撥打會員ID卡背面的會員服務熱線號碼或1-800-565-9140 (標準專線 (TTY): 1-800-848-0298)。

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

주의: 한국어어를 사용하시는 경우, 무료 언어 지원 서비스 및 적절한 보조 도구와 서비스 제공됩니다. 1-800-565-9140 (TTY: 1-800-848-0298) 번호로 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'assurance adhérent ou le 1-800-565-9140 (TTY/AIS : 1-800-848-0298).

внимание: если вы говорите на русском, вы можете получить бесплатную языковую помощь и соответствующие вспомогательные средства. Позвоните в отдел обслуживания участников по номеру 1-800-565-9140 (TTY: 1-800-848-0298).

ध्यान दें: यदि आप हिंदी में बातचीत करते हैं, तो आपको नि:शुल्क भाषा सहायता सेवाएँ और उपयुक्त सहायक उपकरणों और सेवाओं का उपयोग करने के लिए नि:शुल्क कॉल करने के लिए नि:शुल्क कॉल करने का एक विकल्प है। 1-800-565-9140 (TTY: 1-800-848-0298) पर कॉल करें।

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

જાનકારક: જો તમે ગુજરાતી બોલો છો, તો તમારું મુક્ત ભાષા સહાયતા સેવાઓ અને અન્ય સહાયક સાધનો અને સેવાઓનો ઉપયોગ કરવા માટે 1-800-565-9140 (TTY: 1-800-848-0298) નો સંપર્ક કરો.

お知らせ: 日本語をお話になる場合は、無料の支援サービスと適切な補助器具・サービスを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。

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

જાનકારક: જો તમે ગુજરાતી બોલો છો, તો તમારું મુક્ત ભાષા સહાયતા સેવાઓ અને અન્ય સહાયક સાધનો અને સેવાઓનો ઉપયોગ કરવા માટે 1-800-565-9140 (TTY: 1-800-848-0298) પર કોલ કરો.

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 (TTY: 1-800-848-0298).
توجه: اگر یہ زبان فارسی صحبت ہے، تو خدمات کئی زبانیں مل سکتی ہیں۔ یہ خدمات ہاں کئی ممالک میں دستیاب ہیں۔ ڈیڑھ ہفتہ کے لیے مفت کال کرنے کے لیے 1-800-565-9140 (TTY: 1-800-848-0298) پر کال کریں۔

ATENSYON: Si w'apale Kreyòl Ayisyen, genyen sèvis asistans gratis pou lang anseman ak ed pou sèvis oksiyatif apwopriye k'ap disponib pou ou. I 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 otrzymać skorzystanie z pomocy językowej oraz odpowiednie i usług pomocniczych. Posługi zadzwonic pod numer dzialu 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 AKOHWIINDZIN: Dine bizaad bee yanitigo, t'aa jik'eh saad bee aka an'awot, bee aka andarawot' doo t'aa doole e binahiji' bee aadhooniligi' dine biche'i' anidanzat'i' bee bika aninda awot' la darotio. T'aa shoo'di Bil Ha dit'ehi Bika ana'awo' Bil Ha dit'ehi ID naitsoos niki'at' bine de'e' binamboo bee hodilnih doodago 1-800-565-9140 (TTY: 1-800-848-0298).

WICHDICHT: Wenn du Deutsch schweiztscht un brauchtscht Hilf fer communicat-e' kenne mer dich helfe unu as es dich anmit' e' eppes koschood zeill. Mir kenne diframi Saddle Schprooch-Hilf beigrigee aa fer nix. Ruf der Member Service Number uff die himmescht Seit vun dei Member ID Card uff odder 1-800-565-9140 (TTY: 1-800-848-0298).

FAASILASILAGA: Atai e te taitalia i le fae-Samoa, o loo atevano mo oe atevanoa teososani mo gaganai e auroa ma se tologi faepa ma teososani ta'acopo opo ma atuananga tala'ataga'i. Faa'atolemo vale'a au le numera o le Member Service (Auananga mo Tagala Aua'i) o lo'o i tua o lau pepa ID o le Member (Tagala Aua'i) po o le 1-800-565-9140 (TTY: 1-800-848-0298).

GAKULA: Gare iga go kapetal Faluwasch, ye toore palluwal Yamem bwe tepangng tel gamatellal lane kapatal Faluwasch. Fale pesthem kol yegilil nampai Member Service la yelag luqul taquru Member ID kard la yam gare 1-800-565-9140 (TTY: 1-800-848-0298).
ATENSIÓN: Gahra sehisio silha para haqu yanggen ririno' Chahoru hao, d'at'at'ala na sehisio inayudon tumino' Chahoru yan propu na inasisten trastes yan sehisio silha. Put lubat agangri n'umun Sehisio Membro gi santaten i kaha-nu Member ID pat 1-800-565-9140 (TTY: 1-800-848-0298).