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 1-888-796-0609 (TTY: 1-800-848-0299) or visit us at 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 1-888-796-0609 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $750 person/$1,500 family Out-of-network: $1,500 person/$3,500 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive services, Office visits, and Emergency room visits are covered before you meet your deductible (unless specified).	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. Pharmacy In-Network Deductible: $250 per person / $500 family for Brand, Non-Preferred & Specialty drugs. Pharmacy Out-of-Network Deductible: $500 per-person / $1,000 family for Brand, Non-Preferred & Specialty drugs. Pharmacy deductible is separate from medical deductible. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-network: $6,000 person/$12,000 family Out-of-network: $12,000 person/$24,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	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 network provider?	Yes. See www.bcbst.com/network-p or call 1-888-796-0609 for a list of in- network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	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 Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 - In-Network Provider Baptist, LeBonheur, & Regional One (You will pay the least)	Tier 2 - In-Network Provider Methodist & St. Francis (You will pay the least)	Tier 3 - Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay/visit deductible does not apply.	$15 copay/visit deductible does not apply.	50% coinsurance	Teladoc Health: $0.00 copay
	Specialist visit	$30 copay/visit deductible does not apply.	$30 copay/visit deductible does not apply.	50% coinsurance	Office surgery subject to deductible/coinsurance.
	Preventive care/screening/ immunization	No Charge	No Charge	Not Covered	A1c testing will be covered at 100%. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 - In-Network Provider Baptist, LeBonheur, & Regional One (You will pay the least)	Tier 2 - In-Network Provider Methodist & St. Francis (You will pay the least)	Tier 3 - Out-of-Network Provider (You will pay the most)	
					Travel immunization not covered in office or clinic setting.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	50% coinsurance	Diagnostic testing benefits are determined by place of service, such as office or ER.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	50% coinsurance	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 **prescription drug coverage** is available at www.bcbst.com/rxp	Generic drugs	Retail (30 Day Supply) $7 copay/prescription deductible is waived. Mail Order (90 Day Supply) $14 copay/prescription deductible is waived.	Retail (30 Day Supply) $7 copay/prescription deductible is waived. Mail Order (90 Day Supply) $14 copay/prescription deductible is waived.	50% coinsurance after deductible	30 day supply for Retail Network; up to 90 day supply for Home Delivery or Plus90 Network 2 times Retail Copayment up to 90 day supply. Brand drugs subject to $250 deductible.
	Preferred brand drugs	Retail (30 Day Supply) Deductible then $30 copay/prescription. Mail Order (90 Day Supply) Deductible then $60 copay/prescription.	Retail (30 Day Supply) Deductible then $30 copay/prescription. Mail Order (90 Day Supply) Deductible then $60 copay/prescription.	50% coinsurance after deductible	30 day supply for Retail Network; up to 90 day supply for Home Delivery or Plus90 Network 2 times Retail Copayment up to 90 day supply. Brand drugs subject to $250 deductible. When a brand drug is chosen and a generic drug equivalent is available, you will pay a penalty
	Non-preferred brand drugs	Retail (30 Day Supply) Deductible then $50 copay/prescription.	Retail (30 Day Supply) Deductible then $50 copay/prescription.	50% coinsurance after deductible	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 - In-Network Provider Baptist, LeBonheur, & Regional One (You will pay the least)	Tier 2 - In-Network Provider Methodist & St. Francis (You will pay the least)	Tier 3 - Out-of-Network Provider (You will pay the most)	
		Mail Order (90 Day Supply) Deductible then $100 copay/prescription.	Mail Order (90 Day Supply) Deductible then $100 copay/prescription		for the difference between the cost of the brand drug and the generic drug, plus the generic drug copayment or coinsurance.
	Specialty drugs	Preferred brand drugs Deductible then $30 copay/prescription. Non-preferred brand drugs Deductible then $50 copay/prescription.	Preferred brand drugs Deductible then $30 copay/prescription. Non-preferred brand drugs Deductible then $50 copay/prescription.	Not Covered	Up to a 30 day supply. Must use a pharmacy in the Specialty Pharmacy Network. Brand Drugs subject to $250.00 deductible.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	50% coinsurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 60% if not obtained.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	50% coinsurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 60% if not obtained.
If you need immediate medical attention	Emergency room care	$300 copay/visit then deductible/20% coinsurance	$300 copay/visit then deductible/20% coinsurance	$300 copay/visit then deductible/20% coinsurance	*Copay waived if admitted to the hospital.
	Emergency medical transportation	20% coinsurance	20% coinsurance	20% coinsurance	None
	Urgent care	$75 copay deductible does not apply.	$75 copay deductible does not apply.	$75 copay/visit then deductible/50% coinsurance	Office surgery subject to deductible/coinsurance.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 - In-Network Provider Baptist, LeBonheur, & Regional One (You will pay the least)	Tier 2 - In-Network Provider Methodist & St. Francis (You will pay the least)	Tier 3 - Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	$100 copay/visit then deductible/40% coinsurance	$300 copay/visit then deductible/50% coinsurance	*Tier 2 copay/visit waived if admitted through ER then 20% coinsurance. Prior Authorization required. Your cost share may increase to 60% if not obtained.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	50% coinsurance	Prior Authorization required. Your cost share may increase to 60% if not obtained.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 - In-Network Provider Baptist, LeBonheur, & Regional One (You will pay the least)	Tier 2 - In-Network Provider Methodist & St. Francis (You will pay the least)	Tier 3 - Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Office Visit	$10 copay/visit deductible does not apply for office visits	$10 copay/visit deductible does not apply for office visits	50% coinsurance	*$0 copay/visits 1 – 10. *$10 copay/visits starts visit 11. Prior Authorization required for certain outpatient services. Your cost share may increase to 60% if not obtained.
	Outpatient services	20% coinsurance	40% coinsurance	50% coinsurance	Prior Authorization required for certain outpatient services. Your cost share may increase to 60% if not obtained.
	Inpatient services	20% coinsurance	$100 copay/visit then deductible/40% coinsurance	$300 copay/visit then deductible/50% coinsurance	Prior Authorization required. Your cost share may increase to 60% if not obtained.
If you are pregnant	Office visits	$15 copay/visit deductible does not apply.	$15 copay/visit deductible does not apply.	50% coinsurance	Teladoc Health: $0.00 copay
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	50% coinsurance	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		$300 copay/visit then deductible/50% coinsurance	This service may be covered under the Specialty Care

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 - In-Network Provider Baptist, LeBonheur, & Regional One (You will pay the least)	Tier 2 - In-Network Provider Methodist & St. Francis (You will pay the least)	Tier 3 - Out-of-Network Provider (You will pay the most)	
			$100 copay/visit then deductible/40% coinsurance		Program. Cost Share may vary; use a Blue Distinction Center for best benefit.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	50% coinsurance	Unlimited visits per annual benefit period.
	Rehabilitation services	$30 copay/visit deductible does not apply.	$30 copay/visit deductible does not apply.	50% coinsurance	Physical, Speech, Occupational, Cognitive Therapy and Pulmonary Rehabilitation are limited to 60 days combined. Cardiac Rehabilitation is limited to 36 visits per year.
	Habilitation services	$30 copay/visit deductible does not apply.	$30 copay/visit deductible does not apply.	50% coinsurance	Physical, Speech, Occupational, Cognitive Therapy and Pulmonary Rehabilitation are limited to 60 days combined. Cardiac Rehabilitation is limited to 36 visits per year.
	Chiropractic care	$30 copay/visit deductible does not apply.	$30 copay/visit deductible does not apply.	Not Covered	Limited to 20 days per year.
	Acupuncture	$30 copay/visit deductible does not apply.	$30 copay/visit deductible does not apply.	50% coinsurance	Limited to 20 days per year.
	Skilled nursing care	20% coinsurance	$100 copay/visit then deductible/40% coinsurance	$300 copay/visit then deductible/50% coinsurance	Skilled nursing and rehabilitation facility

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 - In-Network Provider Baptist, LeBonheur, & Regional One (You will pay the least)	Tier 2 - In-Network Provider Methodist & St. Francis (You will pay the least)	Tier 3 - Out-of-Network Provider (You will pay the most)	
					limited to 70 days combined per year.
	Durable medical equipment	20% coinsurance	20% coinsurance	Not Covered	Prior Authorization may be required for certain durable medical equipment. Your cost share may increase to 60% if not obtained.
	Hospice services	20% coinsurance	40% 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	Not Covered	None
	Children's glasses	Not Covered	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	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.)

- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine eye care (Children)
- Routine foot care for non-diabetics
- Weight loss programs

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

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Fertility treatment (All Services covered with a $30,000 ($15,000 medical / $15,000 pharmacy) Lifetime maximum benefit.
- Hearing aids for adults
- Hearing aids for children under 18

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.

- 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.
- For church plans, the State Division of Benefits Administration at 1-866-576-0029.
- BlueCross at 1-800-565-9140 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 Health Insurance Marketplace. For more information about the Marketplace, visit 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:

- BlueCross at 1-800-565-9140 or 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.
- 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. 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/No].
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/No].
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. Your City of Memphis plan document will supercede.

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

The plan's overall deductible	**$750**
Specialist copay	**$30**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$800
Copayments	$40
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$2,960**

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

The plan's overall deductible	**$750**
Specialist copay	**$30**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$300
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$1,330**

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

The plan's overall deductible	**$750**
Specialist copay	**$30**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$800
Copayments	$700
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,700**

***This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services"?**
The **plan** would be responsible for the other costs of these EXAMPLE covered services.

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[1]. 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/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.

[1] 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).

انتباه: إذا كنت تتحدث العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية والخدمات والأدوات المساعدة المناسبة. يُرجى الاتصال برقم خدمة الأعضاء الموجود على ظهر بطاقة هوية العضو الخاص بك أو بالرقم 1-800-565-9140 (الهاتف النصي: 1-800-848-0298)

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 ngôn 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).

เอาใจใส่: ถ้าท่านเว้าพาสา พาสาลาว, มีการบໍລิการ ช่วยเหຼือด้านพาสา และ การช่วยเหຼือ และ การบໍລิการที่ เหมาะสົมให้ท่าน. กะลุนาโทหาเบิ่ดของฝ่ายบໍລิการสะมาຊิก ที่มีຢู่ด้านหຼັงบัด ID สะมาຊิกของท่าน 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 સેવાઓ અને યોગ્ય સહાયક સાધનો અને સેવાઓ ઉપલબ્ધ છે. કૃપા કરીને તમારા સભ્ય ID કાર્ડની પાછળના સભ્ય સર્વિસ 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 o sa 1-800-565-9140 (TTY: 1-800-848-0298).

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए नि:शुल्क भाषा सहायता सेवाएँ और उपयुक्त सहायक साधन और सेवाएँ उपलब्ध हैं। कृपया अपने सदस्य ID कार्ड के पीछे दिए गए सदस्य सेवा नंबर 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 (TTY: 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 1-800-565-9140 (TTY: 1-800-848-0298) تماس بگیرید.

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 yáníłti'go, t'áá jiik'eh saad bee áka'anáwo' bee áka'anída'awo'í dóó t'áadoole'é binahjí' bee adahodooníłígíí diné bich'į' anídahazt'i'í bee bika'aanída'awo'í ná dahóló. T'áá shóódí Bił Ha'dít'éhí Bika'aná'awo' Bił Ha'dít'éhí ID naaltsoos nitł'ízí bine'dęę' 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).