



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 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 www.cciio.cms.gov or call 1-800-565-9140 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	In Network: \$6,000/Individual, \$12,000/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 care and primary care services are covered before you meet your deductible .	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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	In Network: \$8,900/Individual, \$17,800/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.
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-s or call 1-800-565-9140 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
		In Network (You will pay the least)	Out of Network (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	\$40 <u>copayment</u> /visit, <u>Deductible</u> does not apply	Not Covered	\$0 virtual care for telehealth services available through Teladoc with your <u>plan</u> . Regular benefits apply for Telehealth provided by other <u>network providers</u> .
	<u>Specialist</u> visit	\$80 <u>copayment</u> /visit, <u>Deductible</u> does not apply	Not Covered	None
	<u>Preventive care/screening</u> /immunization	No Charge	Not Covered	1 visit per Calendar Year. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need 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)	40% <u>coinsurance</u> after <u>deductible</u>	Not Covered	Diagnostic testing benefits are determined by place of service, such as office or ER.
	Imaging (CT/PET scans, MRIs)	40% <u>coinsurance</u> after <u>deductible</u>	Not Covered	Prior Authorization required for certain outpatient services. Penalties include reduced benefits or denial of claim. *See Prior Authorization section.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at https://www.bcbst.com/docs/providers/2026-essential-formulary.pdf	Generic drugs	\$20 <u>copayment</u> , <u>Deductible</u> does not apply	Not Covered	30-day supply retail; up to 90-day supply home delivery.
	Preferred brand drugs	\$40 <u>copayment</u> , <u>Deductible</u> does not apply	Not Covered	30-day supply retail; up to 90-day supply home delivery. When a Brand Drug is chosen and a Generic Drug equivalent is available, You will pay a Penalty for the difference between the cost of the Brand Drug and the Generic Drug.
	Non-preferred brand drugs	\$80 <u>copayment</u> after <u>deductible</u>	Not Covered	
	<u>Specialty drugs</u>	\$350 <u>copayment</u> after <u>deductible</u>	Not Covered	Up to a 30-day supply. Must use a pharmacy in the preferred specialty pharmacy network. Certain <u>Specialty Drugs</u> require authorization from the <u>plan</u> or benefits will be reduced.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network (You will pay the least)	Out of Network (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% <u>coinsurance</u> after <u>deductible</u>	Not Covered	Prior Authorization required for certain outpatient procedures. Penalties include reduced benefits or denial of claim.
	Physician/surgeon fees	40% <u>coinsurance</u> after <u>deductible</u>	Not Covered	Prior Authorization required for certain outpatient procedures. Penalties include reduced benefits or denial of claim.
If you need immediate medical attention	Emergency room care	40% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	Out-of-Network benefits available for true emergency only; Out-of-Network non-emergent benefits are not available.
	Emergency medical transportation	40% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	Out-of-Network benefits available for true emergency only; Out-of-Network non-emergent benefits are not available.
	Urgent care	\$60 <u>copayment</u> /visit, <u>Deductible</u> does not apply	Not Covered	Benefits displayed are for <u>urgent care</u> services received at an <u>urgent care</u> clinic.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% <u>coinsurance</u> after <u>deductible</u>	Not Covered	Prior Authorization for Covered Services must be obtained or benefits will be reduced or denied.
	Physician/surgeon fees	40% <u>coinsurance</u> after <u>deductible</u>	Not Covered	Prior Authorization for Covered Services must be obtained or benefits will be reduced or denied.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 <u>copayment</u> /office visit and 40% <u>coinsurance</u> after <u>deductible</u> for other outpatient services	Not Covered	Prior Authorization required for certain outpatient procedures. Penalties include reduced benefits or denial of claim.
	Inpatient services	40% <u>coinsurance</u> after <u>deductible</u>	Not Covered	Prior Authorization required. Penalties include reduced benefits or denial of claim.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network (You will pay the least)	Out of Network (You will pay the most)	
If you are pregnant	Office visits	\$40 <u>copayment</u> /visit, <u>Deductible</u> does not apply	Not Covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	40% <u>coinsurance</u> after <u>deductible</u>	Not Covered	None
	Childbirth/delivery facility services	40% <u>coinsurance</u> after <u>deductible</u>	Not Covered	None
If you need help recovering or have other special health needs	Home health care	40% <u>coinsurance</u> after <u>deductible</u>	Not Covered	Physical, speech or occupational therapy services provided in the home apply to the therapy services visit limit per therapy type. Prior Authorization may be required for certain home health services.
	Rehabilitation services	\$40 <u>copayment</u> /visit for physical, occupational, speech therapy and 40% <u>coinsurance</u> after <u>deductible</u> for other outpatient services	Not Covered	Therapy limited to 20 visits per therapy type per calendar year. Cardiac/ Pulmonary Rehab limited to 36 visits per calendar year.
	Habilitation services	\$40 <u>copayment</u> /visit, <u>Deductible</u> does not apply	Not Covered	Therapy limited to 20 visits per therapy type per Calendar Year.
	Skilled nursing care	40% <u>coinsurance</u> after <u>deductible</u>	Not Covered	Skilled Nursing and Rehabilitation Facility limited to 60 days combined per Calendar Year. Prior Authorization for Covered Services must be obtained or benefits will be reduced or denied.
	Durable medical equipment	40% <u>coinsurance</u> after <u>deductible</u>	Not Covered	Certain <u>durable medical equipment</u> requires Prior Authorization. Penalties include reduced benefits or denial of claim.
	Hospice services	40% <u>coinsurance</u> after <u>deductible</u>	Not Covered	<u>Medically Necessary</u> and Appropriate services and supplies for supportive care where life expectancy is six months or less. Prior Authorization for inpatient hospice must be obtained or benefits will be reduced or denied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network (You will pay the least)	Out of Network (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	1 exam per Calendar Year.
	Children's glasses	No Charge	Not Covered	1 pair per Calendar Year.
	Children's dental check-up	No Charge	Not Covered	2 visits per 12 months

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 .)		
• Abortion (except in case of rape, incest, or when life of mother is endangered) • Acupuncture • Bariatric surgery • Cosmetic surgery	• Dental care (Adult) • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing	• Routine eye care (Adult) • Routine foot care • Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care 20 visits per year	• Hearing aids 1 item per ear per 3 years	

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: 1-800-342-4029 for the state insurance department, or the insurer at 1-800-565-9140. 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: Tennessee Department of Commerce and Insurance (TDCI) at 1-800-342-4029 or your [plan](#) at 1-800-565-9140.

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? Not Applicable.

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](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-565-9140.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-565-9140.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-565-9140. Navajo

(Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-565-9140.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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 plan's overall deductible	\$6,000
■ Specialist	\$80
■ Hospital (facility)	40%
■ Other	\$40

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$6,000
Copayments	\$40
Coinsurance	\$1,300
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$6,340

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$6,000
■ Specialist	\$80
■ Hospital (facility)	40%
■ Other	\$40

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$4,400
Copayments	\$800
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$5,200

Mia's Simple Fracture

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

■ The plan's overall deductible	\$6,000
■ Specialist	\$80
■ Hospital (facility)	40%
■ Other	\$40

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$2,500
Copayments	\$300
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

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 sex¹. 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, 1.4, Chattanooga, TN 37402.

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

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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).

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

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)。

LUU 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'adhésion ou le 1-800-565-9140 (TTY/ATS: 1-800-848-0298).

தெரிவிப்பு: நீங்கள் தமிழ் மொழியை பேசுபவராக இருப்பதால், மொழி உதவிகள் மற்றும் உதவகங்கள் கட்டில் இல்லாதது. உதவகங்கள் மற்றும் உதவகங்களைப் பெற, உங்கள் உதவக அட்டையின் பின்னில் உள்ள தொலைபேசி எண் அல்லது 1-800-565-9140 (TTY: 1-800-848-0298) ஐ அழைக்கவும்.

જાણકારી: જો તમે ગુજરાતી બોલો છો, તો તમારા માટે નિ:શુલ્ક ભાષા સહાય સેવાઓ અને મુલાકાત સહાય સેવાઓ અને સહાયક સાધનો ઉપલબ્ધ છે. કૃપા કરીને તમારા સભ્ય ID કાર્ડની પાછળના સભ્ય સેવા નંબર ઉપર અથવા 1-800-565-9140 (TTY: 1-800-848-0298) પર સંપર્ક કરો.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos Sprachassistentendienste 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.

પ્રધાન ધ્યાન: જો તમે ગુજરાતી બોલો છો, તો તમારા માટે નિ:શુલ્ક ભાષા સહાય સેવાઓ અને મુલાકાત સહાય સેવાઓ અને સહાયક સાધનો ઉપલબ્ધ છે. કૃપા કરીને તમારા સભ્ય ID કાર્ડની પાછળના સભ્ય સેવા નંબર ઉપર અથવા 1-800-565-9140 (TTY: 1-800-848-0298) પર 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 serbisyo ng 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).

نوٹ: اگر یہ زبان فارسی صحبت می کنید، خدمات کمک زبانی رایگان و مساعدت ها و خدمات کمکی مناسب در دسترس شما هستند. در صورتیکه عضو هستید، با شماره خدمات اعضا در پشت کارت عضویت خود یا (TTY: 1-800-848-0298) 1-800-565-9140 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 yánil'ti'go, t'áá jik'eh saad bee áka'aná'awo' bee áka'aná'awo'í dóó t'áadoole' é binahj'í bee adahoodonilgii diné bich'í' anidahazt'í'i bee bika'aná'awo'í ná dahóló. T'áá shóódí Bii Ha'dit'éhi Bika'aná'awo' Bii Ha'dit'éhi ID naaltsos nit'fizi bine'déé' binámboo bee hodiilnih doodago 1-800-565-9140 (TTY: 1-800-848-0298).

WICHDICH: Wann Du Deutsch schwetzschst un brauchschtf Hilf fer communicat-e kenne mer dich helfe unni as es dich ennich eppes koschde zellt. Mir kenne differnti Sadde Schprooch-Hilf beigrigee aa fer nix. Ruf der Member Service Nummer 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 auunaga fesoasoani mo gagana e aunoa ma se totogi faapea ma fesoasoani fa'aopo'opo ma auunaga talafeagai. Faamolemole vala'au le numera o le Member Service (Auaunaga mo Tagata Aua'i) o lo'o i tua o lau pepa ID o le Member (Tagata Aua'i) po o le 1-800-565-9140 (TTY: 1-800-848-0298).

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

ATENSIÓN: Guaha setbisio silha para hāgu yanggen fīfīno' CHamoru hao, dibāde na setbisio inayudon fumino' CHamoru yan propriu na inasisten trāstes yan setbisio silha. Put fabot āgang i numiron Setbisio Membro gi santatten i kattā-mu Member ID pat 1-800-565-9140 (TTY: 1-800-848-0298).