of Tennessee: United Cleanup Oak Ridge LLC (ORRCC-PLAN C)

Coverage for: Individual or Family | Plan Type: PPO

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. 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:
What is the overall shared deductible?	In-network: \$0 person/\$0 family Out-of-network: \$100 person/\$200 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 deductible?	Yes. <u>Deductible</u> doesn't apply to preventive care.	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</u> <u>services</u> without cost-sharing 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 embedded <u>out-of-pocket limit</u> for this <u>plan?</u>	In-network: \$600 person/\$1,200 family Out-of-network: \$600 person/\$1,200 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 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 <u>network provider</u> ?	Yes. See http://www.bcbst.com/Network-S or call 1-800-565-9140 for a list of in-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.
Do you need a <u>referral</u> to see a specialist?	No.	You can see the specialist you choose without a referral.

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Questions: Call 1-800-565-9140 or visit us at www.bcbst.com.



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

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
	Primary care visit to treat an injury or illness	No charge	10% coinsurance	Teladoc Health Covered at 100%.
	Specialist visit	No charge	10% <u>coinsurance</u>	None
If you visit a health care <u>provider's</u> office or clinic	Preventive care/screening/ immunization	No Charge	10% <u>coinsurance</u>	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. Travel immunization not covered in office or clinic setting.
K	<u>Diagnostic test</u> (x-ray, blood work)	No charge	10% <u>coinsurance</u>	None
If you have a test	Imaging (CT/PET scans, MRIs)	No charge	10% coinsurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
	Preferred Generic drugs / Non- Preferred Generic drugs	10% <u>coinsurance</u>	10% coinsurance	30 day supply for Retail Network; Up to 90 day supply; \$5/\$5 or Home Delivery or Plus90 Network
If you need drugs to	Preferred brand drugs	10% coinsurance	10% coinsurance	30-day supply for Retail Network; up to 90 day suppl; \$15/\$15 for Home Delivery or
treat your illness or condition More information about prescription drug coverage is available at www.bcbst.com/rxp	Non-preferred brand drugs	10% coinsurance	10% <u>coinsurance</u>	Plus90 Network 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, plus the non-preferred brand drug copayment or
	Preferred <u>Specialty drugs</u> / Non-Preferred <u>Specialty drugs</u>	10% coinsurance	Not Covered	Up to a 30-day supply. Must use a pharmacy in the Specialty Pharmacy Network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	10% coinsurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 50% if not obtained. *See Prior Authorization section.

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

Common	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
	Physician/surgeon fees	No charge	10% <u>coinsurance</u>	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 50% if not obtained. *See Prior Authorization section.
	Emergency room care	No charge	No charge	None
If you need immediate medical attention	Emergency medical transportation	No charge	No charge	None
	<u>Urgent care</u>	No charge	10% coinsurance	None
If you have a hospital	Facility fee (e.g., hospital room)	No charge	10% coinsurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
stay	Physician/surgeon fees	No charge	10% coinsurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
If you need mental health, behavioral health, or substance	Outpatient services	Office and other outpatient services: No Charge	10% coinsurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 50% if not obtained. *See Prior Authorization section.
abuse services	Inpatient services	No charge	10% coinsurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
	Office visits	No charge	10% coinsurance	Cost sharing does not apply for preventive services.
If you are pregnant	Childbirth/delivery professional services	No charge	10% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. Ultrasound). Initial office visit to confirm pregnancy is subject to the office visit benefit
	Childbirth/delivery facility services	No charge	10% coinsurance	None
	Home health care	No charge	10% coinsurance	Unlimited
If you need help recovering or have	Rehabilitation services	No charge	10% coinsurance	Therapy visits to include acupuncture, chiropractic, physical, speech, and occupational therapies limited to 100 visits combined per year. Cardiac/Pulmonary
				rehab limited to 36 visits per type per year.

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

other special health needs	Habilitation services	No charge	10% <u>coinsurance</u>	Therapy visits to include acupuncture, chiropractic, physical, speech, and occupational therapies limited to 100 visits combined per year. Cardiac/Pulmonary rehab limited to 36 visits per type per year.
	Skilled nursing care	No charge	10% coinsurance	Skilled nursing and rehabilitation facility limited to 120 days combined per year.
Common	What You W		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
	Durable medical equipment	No charge	10% <u>coinsurance</u>	Prior Authorization may be required for certain <u>durable medical equipment</u> . Your cost share may increase to 50% if not obtained. *See Prior Authorization section.
	Hospice services	No Charge	10% coinsurance	Prior Authorization required for inpatient hospice. Your cost share may increase to 50% if not obtained.
If your shild poods	Children's eye exam	Not Covered	Not Covered	None
If your child needs		Not Covered	None	
dental or eye care	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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult) (Children)
- Glasses (Children)

- Long-term care
- Non-emergency care when traveling outside the
- U.S.
   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 <u>plan</u> document.)

AcupunctureChiropractic

- Hearing aids all ages
- Weight loss Medications

- Private-duty nursing
- Infertility treatment Limited to diagnosis and treatment of underlying medical condition

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

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) <a href="https://www.dol.gov/ebsa/healthreform.">www.dol.gov/ebsa/healthreform.</a>
- For non-federal governmental plans, the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or <a href="https://www.cciio.cms.gov">www.cciio.cms.gov</a>.
- 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 <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 <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact:

- BlueCross at 1-800-565-9140 or <u>www.bcbst.com</u>, 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 <a href="https://www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a>.
- 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, <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 <a href="https://cs.complaints@state.tn.us">CIS.Complaints@state.tn.us</a>. 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 <u>plan</u> might cover costs for a sample medical situation, see the next section.

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

### **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>	\$0
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other copay	0%

#### 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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n this example, Peg would pay:		
Cost Sharing		
<u>Deductibles</u>	\$0	
<u>Copayments</u>	\$0	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions \$60		
The total Peg would pay is \$		

# 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>	\$0
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other copay	0%

### This EXAMPLE event includes services like:

Primary care physician office visits (including disease education)

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

Prescription drugs

**Total Example Cost** 

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

In this example, Joe would pay:	
Cost Sharing	
<u>Deductibles</u>	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions \$	
The total Joe would pay is	

# Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
Other copay	0%

#### This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (x-ray)

\$5,600

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

In this example, Mia would pay:

Rehabilitation services (physical therapy)

Total Example Cost	\$2,800

Cost SharingDeductibles\$0Copayments\$0Coinsurance\$0What isn't covered

#### 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 sex¹. 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 (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. 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 المحانية والخدمات والأدوات المساعدة المناسبة. يُرجى الاتصال برقم خدمة الاعضاء الموجود على ظهر بطاقة هوية العضو الخاص بك أو بالرقم 5419-565-800-1 (الهاتف النصي: 8020-848-800-1)

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 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 Thè 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 સેવાઓ અને યોગ્ય સહાયક સાધનો અને સેવાઓ ઉપલબ્ધ છે. કૃષા કરીને તમારા સભ્ય ID કાર્ડની પાછળના સભ્ય સર્વીસ નંબદ ઉપર અથવા 1-800-565-9140 (TTY: 1-800-848-0298) પર કોલ 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).

ध्यान 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 پا 04-565-658-018 (TTY: 1-800-848-0289) 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 jezykowej 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 yánílítí'go, t'áá jiilk'eh saad bee áka'aná'awo' bee áka'anída'awo'i dóó t'áadoole'é binahji' bee adahodoonílígíí diné bich'i' anídahazt'i'i bee bika'aanída'awo'i ná dahóló. T'áá shóódí Bił Ha'dít'éhí Bika'aná'awo' Bił Ha'dít'éhí ID naaltsoos nitl'izi 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 ägang i numiron Setbision Membro gi santatten i kattå-mu Member ID pat 1-800-565-9140 (TTY: 1-800-848-0298).

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