Coverage for: Individual or Family | Plan Type: HDHP

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

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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

Important Questions	Answers	Why This Matters:
What is the shared overall deductible?	In-network: \$3,400 person/ \$6,800 family Out-of-network: \$5,000 person/\$10,000 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> .
Are there services covered before you meet your deductible?	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> .
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: \$6,550 person/\$13,100 family Out-of-network: \$13,100 person/\$26,200 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 <u>out-of-pocket limit?</u>	Premium, balance-billing charges, penalties, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a <u>network provider</u> ?	Yes. See 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 <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

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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	50% coinsurance	50% coinsurance	Teladoc Health: \$45 copay
	Specialist visit	50% coinsurance	50% coinsurance	None
If you visit a health care <u>provider's</u> office or clinic	Preventive care/screening/ immunization	No Charge	50% coinsurance	A1c testing will be covered at 100%. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. Travel immunization not covered in office or clinic setting.
	<u>Diagnostic test</u> (x-ray, blood work)	50% coinsurance	50% coinsurance	None
If you have a test	Imaging (CT/PET scans, MRIs)	50% 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	Preferred Generic drugs / Non- Preferred Generic drugs	30% coinsurance	30% coinsurance	30 day supply for Retail Network; up to 90 day supply for Home Delivery or Plus90 Network. Preventive drugs: Generic and Preferred brand: 30-day: 30% up to \$200 max; 60-day: 30% up to \$400 max; 90-day: 30% up to \$600 max; Non-preferred brand: 30-day: 45% up to \$200 max; 60-day: 45% up to \$400 max; 90-day: 45% up to \$600 max
More information about	Preferred brand drugs	30% coinsurance	50% coinsurance	30 day supply for Retail Network; up to 90
prescription drug coverage is available at www.bcbst.com/rxp	Non-preferred brand drugs	45% coinsurance	45% <u>coinsurance</u>	day supply for Home Delivery or Plus90 Network. Preventive drugs: Generic and Preferred brand: 30-day: 30% up to \$200 max; 60-day: 30% up to \$400 max; 90-day: 30% up to \$600 max; Non-preferred brand: 30-day: 45% up to \$200 max; 60-day: 45% up to \$400 max; 90-day: 45% up to \$600 max

<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		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
	Preferred Specialty drugs / Non-Preferred Specialty drugs	30% coinsurance/ 45% 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)	50% coinsurance	50% coinsurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 60% if not obtained. *See Prior Authorization section.
	Physician/surgeon fees	50% coinsurance	50% coinsurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 60% if not obtained. *See Prior Authorization section.
	Emergency room care	50% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency medical transportation	50% coinsurance	50% coinsurance	None
	Urgent care	50% coinsurance	50% coinsurance	None
If you have a hospital	Facility fee (e.g., hospital room)	50% coinsurance	50% coinsurance	Prior Authorization required. Your cost share may increase to 60% if not obtained.
stay	Physician/surgeon fees	50% coinsurance	50% coinsurance	Prior Authorization required. Your cost share may increase to 60% if not obtained.
If you need mental health, behavioral health, or substance	Outpatient services	Office and other outpatient services: 50% coinsurance	50% coinsurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 60% if not obtained. *See Prior Authorization section.
abuse services	Inpatient services	50% coinsurance	50% coinsurance	Prior Authorization required. Your cost share may increase to 60% if not obtained.
	Office visits	50% coinsurance	50% coinsurance	Cost sharing does not apply for preventive services.
If you are pregnant	Childbirth/delivery professional services	50% coinsurance	50% coinsurance	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	50% coinsurance	50% coinsurance	None
If you need help	Home health care	50% coinsurance	50% coinsurance	Unlimited

 $<sup>^*</sup> For more information about limitations and exceptions, see the plan or policy document at \underline{www.bcbst.com/samplepolicy/2026/LG.pdf}.\\$ 

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	
recovering or have other special health needs	Rehabilitation services	50% coinsurance	50% coinsurance	Therapy visits include acupuncture, chiropractic, physical, speech, and occupational - limited to 40 visits per type per year. Cardiac/Pulmonary rehab limited to 36 visits per type per year.	
	Habilitation services	50% coinsurance	50% coinsurance	Therapy visits include acupuncture, chiropractic, physical, speech, and occupational - limited to 40 visits per type per year. Cardiac/Pulmonary rehab limited to 36 visits per type per year.	
	Skilled nursing care	50% coinsurance	50% coinsurance	Skilled nursing and rehabilitation facility limited to 60 days combined per year.	
	Durable medical equipment	50% coinsurance	50% coinsurance	Prior Authorization may be required for certain <u>durable medical equipment</u> . Your cost share may increase to 60% if not obtained. *See Prior Authorization section.	
	Hospice services	50% coinsurance	50% coinsurance	Prior Authorization required for inpatient hospice. Your cost share may increase to 60% if not obtained.	
If your shild poods	Children's eye exam	Not Covered	Not Covered	None	
If your child needs dental or eye care	Children's glasses	Not Covered	Not Covered	None	
ucilial of eye cale	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)

- Hearing aids for adults
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) (Children)
- Routine foot care for non-diabetics
- Weight loss programs

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

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

- Acupuncture
- Chiropractic care

- Hearing aids for children under 18
- Private duty nursing
- Weight loss medications

 Infertility treatment – limited to the diagnosis and treatment of underlying medical condition

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 <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 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 <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 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, <a href="https://sbs.naic.org/solar-web/pages/public/onlineComplaintForm/onlineComplaintForm.jsf?state=tn&dswid=-8432">https://sbs.naic.org/solar-web/pages/public/onlineComplaintForm/onlineComplaintForm.jsf?state=tn&dswid=-8432</a>, or email them at CIS.Complaints@state.tn.us. You may also write them at 500 James Robertson Pkwy, Davy Crockett Tower, 6th Floor, Nashville, TN 37243.

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

Minimum Essential Coverage generally includes 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 <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 www.bcbst.com/samplepolicy/2026/LG.pdf.

#### **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>	\$3,400
■ Specialist coinsurance	50%
■ Hospital (facility) coinsurance	50%
Other coinsurance	50%

#### 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:

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Cost Sharing		
<u>Deductibles</u>	\$3,400	
<u>Copayments</u>	\$0	
Coinsurance	\$3,300	
What isn't covered		
Limits or exclusions \$20		
The total the family would pay is	\$6,720	

# **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>	\$3,400
■ Specialist coinsurance	50%
■ Hospital (facility) coinsurance	50%
Other coinsurance	50%

#### This EXAMPLE event includes services like:

<u>Primary care physician</u> 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		
<u>Deductibles</u>	\$3,400	
<u>Copayments</u>	\$0	
<u>Coinsurance</u>	\$900	
What isn't covered		
Limits or exclusions \$3		
The total Joe would pay is	\$4,330	

# **Mia's Simple Fracture**

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

■ The <u>plan's</u> overall <u>deductible</u>	\$3,400
■ Specialist coinsurance	50%
Hospital (facility) coinsurance	50%
Other coinsurance	50%

#### This EXAMPLE event includes services like:

<u>Emergency room care</u> (including medical supplies)

Diagnostic test (x-ray)

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

Rehabilitation services (physical therapy)

Total Example Cost	\$2,800

### In this example, Mia would pay:

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

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.

- · 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 rn 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 grievanee {"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: do 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:/locrportal.hhs.govl ocrlportal/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/ocrloffice/filelindex.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 Camaron 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.

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)

ATENCI6N: Si habla espaiiol, tiene a su disposici6n servicios gratuitos de asistencia con el idioma, asf coma ayudas y servicios auxiliares adecuados. Llama al numero de Servido de atenci6n a miembros que figura en el reverso de su tarjeta de identificaci6n de miembro o al 1-800-565-9140 (TTY: 1-800-848-0298).

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ATTENTION : Si vous parlez fram,;ais, des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriEis sont a votre disposition. Veuillez appeler le numero du Service adherents indique au dos de votra carte d'assure adherent ou le 1-800-565-9140 (TTY/ATS: 1-800-848-0298).

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1-800-565-9140 (TTY: 1-800-848-0298)  $\pounds$ , f(J), 'r::

ACHTUNG: Wenn Sie Deutsch sprechen stehen Ihnen kostenlose Sprachassistenzdienste und geeignete Hilfsmittel und Dienstleistungen zur Verfugung. Bitle rufen Sia die Nummer des Mitgliederdienstes auf der R0ckseite Ihrer Mitglieds-ID-Karte oder 1-800-565-9140 (TTY: 1-800-848-0298) an.

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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).

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

UWAGA: Osoby posluguj<1.ce si j zykiem polskim mog<1 bezp!atnie skoizystac z pomocy j zykowej oraz rozwi<1zari i uslug pomocniczych.

Prosimy zadzwaniC pod numer dziafu obstugi ubezpieczonych podany na odwrocie karty identyfikacyjnej czlonka lub numel 1-800-565-9140 (TTY: 1-800-848-0298).

ATEN(:AO: Se voce fala Portugues. servi9os gratuitos de assist9ncia linguistica e recursos e servi9os auxiliares apropriados estiio disponiveis para vocE!. Ligue para a nLImero de telefone do servi90 de Atendimento ao Membro informado no verso de seu cartao de identifica9iio 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 nonch0 aiuti e servizi ausiliari adeguati. Chiami ii 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'aKOHWIINIDZIN: Dine bizaad bee yanfiti'go, t'aa jiik'eh saad bee aka'anc3'awo' bee clka'anfda'awo'f d66 t'aadoole'e binahii' bee adahodoonfHgfi dine bich'i' anidahazt'i'i bee bika'aanida'awo'i na dah61¢. T'aa sh66di Bil Ha'dit'ehf Bika'ana'awo' Bil Ha'dit'ehf ID naaltsoos nitl'izi bine'dEi!f binamboo bee hodiilnih doodago 1-800-565-9140 (TTY: 1-800-848-0298)

WICHDICH: Wann du Deitsch schwetzscht un brauchscht Hilf fer communicat-e kenna 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: Alai e te tautala i le faa Samoa, a 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 hagu yanggen fifino' CHamoru hao, dibatde na setbision inayudon fumino' CHamoru yan propriu na inasisten trastes yan setbisio siha. Put fabot agang i numiron Setbision Membro gi santatten i katta-mu Member ID pat 1-800-565-9140 (TTY: 1-800-848-0298).

<sup>1</sup> Consistent with the scope of sax discrimination described at45 CFR 92.101(a)(2))