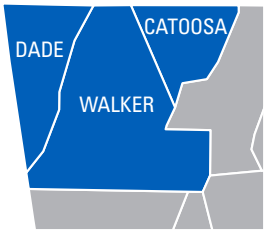
2025 Summary of Benefits

A MEDICARE ADVANTAGE PLAN WITH PART D PRESCRIPTION DRUG COVERAGE



CATOOSA, DADE AND WALKER COUNTIES IN NORTH GEORGIA

Sapphire North Georgia

BlueAdvantage (PPO)℠

of Tennessee

H7917_25SapNGASB_M (08/24)

SUMMARY OF BENEFITS

BlueAdvantage Sapphire

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
Monthly Plan Premium	**$0** per month. You must continue to pay your Medicare Part B premium.
Deductible	Medical Deductible: **No Deductible** Prescription Drug Deductible: **No Deductible**
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: • **$4,200** for services you receive from in-network providers. • **$9,550** for services you receive from in- and out-of-network providers combined. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your cost-sharing for your Part D prescription drugs.
COVERED MEDICAL AND HOSPITAL BENEFITS	
Inpatient Hospital and Inpatient Services in a Psychiatric Hospital Prior authorization is required.	**In-Network:** Days 1-5: **$285** copay per day Additional Days: **$0** copay per day **Out-of-Network:** Days 1-5: **$335** copay per day Additional Days: **$0** copay per day Our plan covers an unlimited number of days for an inpatient hospital stay. You may only receive **190 days in a psychiatric hospital in a lifetime**. The 190-day limit does not apply to mental health services provided in a psychiatric unit of a general hospital.
Outpatient Surgical Services Prior authorization may be required.	**In-Network:** Ambulatory Surgical Center: **$275** copay Outpatient hospital facility: **$225** copay **Out-of-Network:** Ambulatory Surgical Center: **50%** of the Medicare-allowed amount Outpatient hospital facility: **$275** copay

HEALTH BENEFITS	
Doctor Visits	**<u>In-Network:</u>** Primary Care Provider visit: **$0** copay Specialist visit: **$30** copay **<u>Out-of-Network:</u>** Primary Care Provider visit: **$10** copay Specialist visit: **$40** copay

Preventive Care
 	
Our plan covers many preventive services, for example:
• Bone density screenings
• Cardiovascular disease screenings
• Cervical & vaginal cancer screenings
• Colorectal cancer screenings
• Diabetes screenings
• Glaucoma tests
• Mammogram screenings
• Prostate cancer screenings
• Vaccines:
  ➢ COVID-19
  ➢ Flu
  ➢ Hepatitis B
  ➢ Pneumococcal
 	
Additional preventive services approved by Original Medicare will be covered for dates of services on or after approval by Original Medicare.
	<u>In-Network:</u>
	$0 copay
	<u>Out-of-Network:</u>
	50% of the Medicare-allowed amount

Emergency Care	**<u>Domestic:</u>** **$125** copay per visit **<u>Worldwide:</u>** **$90** copay per visit Copay is waived if you are admitted to the hospital within 24 hours for the same condition. All emergency care is considered in network.

HEALTH BENEFITS	
Urgently Needed Services	**Domestic:** **$25** copay per visit **Worldwide:** **$90** copay per visit Copay is waived if you are admitted to the hospital within 24 hours for the same condition. All emergency care is considered in network.
Diagnostic Services / Labs/ Imaging Prior authorization may be required.	**In-Network:** **Diagnostic tests and procedures:** **$0** copay at a Primary Care Provider's office **$30** copay at a Specialist's office **$40** copay at a Free Standing Facility **$100** copay at an Outpatient Hospital **Lab services:** **$0** copay at a Primary Care Provider's office **$0** copay at a Specialist's office **$0** copay at a Free Standing facility **$40** copay at an Outpatient Hospital **X-rays:** **$0** copay at a Primary Care Provider's office **$30** copay at a Specialist's office **$40** copay at a Free Standing Facility **$50** copay at an Outpatient Hospital **Therapeutic Radiology Services:** **$60** copay **Advanced Imaging (such as MRI, CT scans):** **$225** copay **Coumadin Services:** **$0** copay at a Primary Care Provider's office **$0** copay at a Specialist's office **$0** copay at a Free Standing Facility **$10** copay at an Outpatient Hospital **Sleep Studies:** **$10** copay for in-home **$40** copay at an Outpatient Facility **Out-of-Network:** **Diagnostic tests and procedures:** **$10** copay at a Primary Care Provider's office

	$40 copay at a Specialist's office **50%** of the Medicare-allowed amount at a Free Standing Facility **50%** of the Medicare-allowed amount at an Outpatient Hospital **Lab services:** **$10** copay at a Primary Care Provider's office **$40** copay at a Specialist's office **50%** of the Medicare-allowed amount at a Free Standing Facility **50%** of the Medicare-allowed amount at an Outpatient Hospital **X-rays:** **$10** copay at a Primary Care Provider's office **$40** copay at a Specialist's office **50%** of the Medicare-allowed amount at a Free Standing Facility **50%** of the Medicare-allowed amount at an Outpatient Hospital **Therapeutic Radiology Services:** **50%** of the Medicare-allowed amount **Advanced Imaging (such as MRI, CT scans):** **50%** of the Medicare-allowed amount **Coumadin Services:** **$10** copay at a Primary Care Provider's office **$40** copay at a Specialist's office **50%** of the Medicare-allowed amount at a Free Standing Facility **50%** of the Medicare-allowed amount at an Outpatient Hospital **Sleep Studies:** **50%** of the Medicare-allowed amount for in-home **50%** of the Medicare-allowed at an Outpatient Facility
Hearing Services Cost-sharing for hearing aids does not count toward the maximum out-of-pocket amount.	In-Network: **Medicare-covered exam** to diagnose and treat hearing and balance issues: **$10** copay **Routine hearing exam** (1 visit per year): **$0** copay at TruHearing® provider **Hearing Aids:** **$399 (Standard)** copay **$599 (Advanced)** copay **$899 (Premium)** copay Copay depending on model. Limited to one per ear per year. Benefit is limited to TruHearing Standard, Advanced and Premium hearing aids, which come in various styles and colors. You must see a TruHearing provider to use this benefit.

	Out-of-Network: Medicare-covered exam to diagnose and treat hearing and balance issues: **$10** copay Routine hearing exam: Not covered Hearing Aids: Not covered
Dental Services Comprehensive and preventive dental benefits do not count toward the maximum out-of-pocket amount. (Service limits and other restrictions may apply to the comprehensive dental benefits.) Included as covered benefits with service limits in this plan, but not limited • Standard diagnostic exam (limited to 2 per year) • Problem-focused oral evaluations • Cleaning (limited to 2 per year) • Bitewing x-ray (limited to 1 per year) • Panoramic x-ray (limited to 1 per 36 months) • Fillings (limited to 1 per tooth service per year) • Crowns (limited to 1 per tooth per 5 years) • Extractions • Bridges (limited to 1 per 5 years) • Removable dentures; complete, immediate, and partial (limited to 1 in any 5 year period)	**In-Network:** Medicare-covered: **$30** copay Our plan pays up to **$2,750** per year for combined preventive and comprehensive dental services. If the total covered cost for dental services is more than **$2,750** or if you exceed a service limit, you are required to pay the difference. **Out-of-Network:** Medicare-covered: **50%** of the Medicare-allowed amount Our plan pays **50%** of billed charges up to **$2,750**. You pay **100%** of any charges over **$2,750**.

HEALTH BENEFITS	
Vision Services Members are encouraged to use the defined vision care network to obtain routine eye exam and eyewear benefit coverage. Routine eye exam and eyewear copays do not apply to the maximum out-of-pocket amount.	**<u>In- and Out-of-Network:</u>** Medicare-covered exam to diagnose and treat diseases and conditions of the eye: **$0** copay Routine eye exam (1 per year): **$0** copay Eyeglasses or contact lenses after cataract surgery: **$0** copay Our plan pays a maximum of **$250** per year for routine eyewear. There is no copay for eyeglasses (frames and lenses) or contact lenses. But, if your total eyewear cost is more than **$250**, you will be required to pay the difference. For example, If your total cost for eyewear is **$300**, your plan will pay **$250** and you will pay **$50**.
Outpatient Mental Health Care Prior authorization is required.	**<u>In-Network:</u>** Outpatient group therapy visit: **$20** copay Individual therapy visit: **$30** copay **<u>Out-of-Network:</u>** Outpatient group therapy visit: **50%** of the Medicare-allowed amount Individual therapy visit: **50%** of the Medicare—allowed amount
Skilled Nursing Facility (SNF) Prior authorization is required**.**	**<u>In-Network:</u>** Days 1-20: **$0** copay per day Days 21-100: **$214** copay per day **<u>Out-of-Network:</u>** **50%** of the Medicare-allowed amount per stay The amounts above apply per benefit period. Our plan covers up to 100 days in a SNF per benefit period. A benefit period begins the day you go into a SNF. The benefit period ends when you haven't received any inpatient hospital care or skilled care in a SNF for 60 days in a row. If you go into a SNF after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

HEALTH BENEFITS	
Outpatient Rehabilitation Services (Physical Therapy) Prior authorization is required.	**In-Network:** Occupational therapy visit: **$30** copay Physical therapy visit: **$30** copay Speech and language therapy visit: **$30** copay **Out-of-Network:** Occupational therapy visit: **50%** of the Medicare-allowed amount Physical therapy visit: **50%** of the Medicare-allowed amount Speech and language therapy visit: **50%** of the Medicare-allowed amount
Ambulance Prior authorization is required for all non-emergency ambulance transport. See the EOC for details regarding worldwide emergency transportation.	**Domestic:** Ground Ambulance: **$295** copay per one-way trip Air Ambulance: **20%** of the Medicare-allowed amount per one-way trip **Worldwide:** Ground Ambulance: **$295** copay per one-way trip Air Ambulance: **20%** of the Plan-allowed amount per one-way trip
Transportation	Not covered
Medicare Part B Drugs Prior authorization may be required.	**In-Network:** Part B chemotherapy drugs: **20%** of the Plan-allowed amount Other Part B drugs: **20%** of the Plan-allowed amount Part B insulin: **20%** of the Plan-allowed amount, with a **$35** maximum copay for a one-month supply of a covered insulin product **Out-of-Network:** Part B chemotherapy drugs: **50%** of the Medicare-allowed amount Other Part B drugs: **50%** of the Medicare-allowed amount Part B insulin: **20%** of the Medicare-allowed amount, with a **$35** maximum copay for a one-month supply of a covered insulin product

PRESCRIPTION DRUG BENEFITS		
Deductible	This plan does not have a deductible for Part D prescription drug benefits. Prescription drug copays and coinsurance do not apply to the maximum out-of-pocket.	
Initial Coverage	You pay the following until your total yearly drug costs reach **$2,000**. Total yearly drug costs are the drug costs paid by both you and our Part D plan.	
	Preferred Retail and Mail Order Pharmacy **30 / 100 Day Supply**	**Standard Retail and Mail Order Pharmacy** **30 / 100 Day Supply**
Tier 1 (Preferred Generic)	$0 / $0	$6 / $15
Tier 2 (Generic)	$10 / $10	$15 / $35
	Preferred Retail and Mail Order Pharmacy **30 / 90 Day Supply**	**Standard Retail and Mail Order Pharmacy** **30 / 90 Day Supply**
Tier 3 (Insulin)	$35 / $105	$35 / $105
Tier 3 (Preferred Brand)	$42 / $105	$47 / $135
Tier 4 (Non-Preferred Drugs)	50% coinsurance	50% coinsurance
Tier 5 (Specialty Tier)	33% coinsurance	33% coinsurance
	You won't pay more than **$35** for a one-month supply of each covered insulin product regardless of the cost-sharing tier.	
Catastrophic Coverage Stage	After your yearly out-of-pocket drug costs reach $2,000, the plan pays the full cost for your covered Part D drugs.	

Additional Covered Drugs
Our plan has additional coverage for the prescription drugs listed below. They're covered at a Tier 2 cost share. They're not normally covered in a Medicare Advantage plan with prescription drug coverage. The amount you pay for these drugs doesn't count toward your total drug costs or help you qualify for catastrophic coverage. If you get "Extra Help" to pay for your prescriptions, it doesn't apply to these drugs.

Respiratory and Allergy, Vitamins, and Erectile Dysfunction

ADDITIONAL HEALTH BENEFITS	
24/7 NurseLine	**In-Network:** **$0** copay **Out-of-Network:** Not covered
Acupuncture Prior authorization is required.	**In-Network:** **$20** copay **Out-of-Network:** **50%** of the Medicare-allowed amount
Chiropractic Care Prior authorization is required.	Manual manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position). **In-Network:** **$20** copay **Out-of-Network:** **50%** of the Medicare-allowed amount
Diabetic Supplies and Services Prior authorization may be required.	**Diabetes self-management training:** **In-Network:** **$0** copay **Out-of-Network:** **20%** of the Medicare-allowed amount **Diabetes monitoring supplies:** **In-Network:** **Preferred: $0** copay **Non-Preferred: 20%** of the plan-allowed amount **Out-of-Network:** **50%** of the Medicare-allowed amount **Therapeutic shoes/inserts:** **In-Network:** **$10** copay **Out-of-Network:** **50%** of the Medicare-allowed amount

ADDITIONAL HEALTH BENEFITS	
Durable Medical Equipment Prior authorization may be required.	**In-Network:** **20%** of the plan-allowed amount **Out-of-Network:** **50%** of the Medicare-allowed amount
Home Health Care Prior authorization is required.	**In-Network:** **$0** copay **Out-of-Network:** **50%** of the Medicare-allowed amount
Meal Benefit	**In-Network:** **$0** copay Meal benefit includes 14 meals following an acute inpatient, SNF discharge, or observation stay to a home setting. There is not a limit to the number of discharges for meals. Must use designated vendor. **Out-of-Network:** Not covered
Outpatient Rehabilitation (Cardiac & Pulmonary) Prior authorization is required.	**Cardiac (heart) rehab services:** **In-Network:** **$20** copay **Out-of-Network:** **50%** of the Medicare-allowed amount **Pulmonary (lung) rehab services:** **In-Network:** **$15** copay **Out-of-Network:** **50%** of the Medicare-allowed amount

ADDITIONAL HEALTH BENEFITS	
Over-the-Counter (OTC) Items	**In-Network:** The plan pays **$60** per quarter (no roll-over) for certain OTC items such as vitamins, cough/cold/allergy medicines, dental products and skin care items. Must use designated vendor. **Out-of-Network:** Not covered
Prosthetic Devices Prior authorization may be required.	**In-Network:** Prosthetic devices: **20%** of the Plan-allowed amount Related medical supplies: **20%** of the Plan-allowed amount **Out-of-Network:** **50%** of the Medicare-allowed amount
Renal Dialysis	**In-Network:** **20%** of the Plan-allowed amount **Out-of-Network:** **20%** of the Medicare-allowed amount
Fitness Program This plan includes a free standard fitness center membership, tools and online resources.	**In-Network:** **You pay nothing.** **Out-of-Network:** Not covered

DISCLAIMERS

This is a summary of drugs and health services covered by BlueAdvantage Sapphire Preferred Provider Organization (PPO) Sapphire North Georgia health plan January 1, 2025 through December 31, 2025.

BlueAdvantage is a Local PPO plan with a Medicare contract. Enrollment in BlueAdvantage depends on contract renewal.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, go to **bcbstmedicare.com** or call us and ask for the "**Evidence of Coverage**."

To join BlueAdvantage, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and you must live in our service area. Our service area includes:

Northern counties in Georgia: Catoosa, Dade and Walker

This document is available in other alternate formats.

This document may be available in a non-English language. For additional information, call us at **1-800-831-2583**, TTY **711**.

BlueAdvantage plans have a network of doctors, hospitals, pharmacies, and other providers. If you use the providers in our network, you may pay less for your covered services. In most cases, you can use providers that are not in our network as long as they accept Medicare. You may pay more for care from an out-of-network provider.

Out-of-network/non-contracted providers are under no obligation to treat BlueCross BlueShield of Tennessee members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our Member Services number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

If you have any questions about this plan's benefits or costs,
please contact BlueCross BlueShield of Tennessee.

BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the Blue Cross Blue Shield Association

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to our representative at **1-800-292-5146**, TTY **711**.

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit **bcbstmedicare.com** or call **1-800-292-5146**, TTY **711**, to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ In addition to your monthly plan premium*, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/ coinsurance may change on January 1, 2026.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher copay for services received by non-contracted providers.
- ☐ Effect on Current Coverage: If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.

*BlueAdvantage Sapphire (PPO)SM and BlueAdvantage Garnet (PPO)SM plans have a $0 plan premium.

Note: For BlueAdvantage Prime (PPO)SM there are limited times when you can add or remove the Optional Supplemental Benefits: Dental and Vision package.

of Tennessee

Nondiscrimination Notice

BlueCross BlueShield of Tennessee (BlueCross), including its subsidiaries SecurityCare of Tennessee, Inc. and Volunteer State Health Plan, Inc. also doing business as BlueCare Tennessee, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BlueCross does not exclude people or treat them less favorably because of race, color, national origin, age, disability or sex.

BlueCross:

Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as: (1) qualified sign language interpreters and (2) written information in other formats, such as large print, audio and accessible electronic formats.

Provides free language assistance services to people whose primary language is not English, such as: (1) qualified interpreters and (2) information written in other languages.

If you need these reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact Member Service at the number on the back of your Member ID card or call **1-800-831-2583**, TTY **711**. From **Oct. 1 to March 31**, you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From **April 1 to Sept. 30**, you can call us Monday through Friday from 8 a.m. to 9 p.m. ET. Our automated phone system may answer your call outside of these hours and during holidays.

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 Member Service at the number on the back of your Member ID card or call **1-800-831-2583**, TTY **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 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, 1-800-537-7697 (TDD), 8:30 a.m. to 8 p.m. ET. Complaint forms are available at hhs.gov/ocr/office/file/index.html.

You can contact BlueCross's Nondiscrimination Coordinator at 423-535-1010 (phone), 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

H7917_25NDMLI_C (07/24)

Form Approved
OMB# 0938-1421

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-831-2583, TTY 711. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-831-2583, TTY 711. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-831-2583, TTY 711。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-831-2583, TTY 711。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-831-2583, TTY 711. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-831-2583, TTY 711. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-831-2583, TTY 711 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-831-2583, TTY 711. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-831-2583, TTY 711 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-831-2583, TTY 711. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-831-2583, TTY 711 . سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध है. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-831-2583, TTY 711 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-831-2583, TTY 711. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-831-2583, TTY 711. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-831-2583, TTY 711. Yon moun ki pale Kreyòl kapab ede w.
Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-831-2583, TTY 711. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-831-2583, TTY 711 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Notes

We're right here when you need us.

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If you are a member, call toll-free
1-800-831-2583 TTY **711**.

If you are not a member, call toll-free
1-800-292-5146 TTY **711**.

OCT. 1 TO MARCH 31, SEVEN DAYS A WEEK FROM 8 A.M. TO 9 P.M. ET. FROM **APRIL 1 TO SEPT. 30**, M-F FROM 8 A.M. TO 9 P.M. ET.

of Tennessee