BlueCross BlueShield of Illinois

# 2027 Summary of Benefits

## Blue Cross Medicare Advantage Basic (HMO-POS)SM

January 1, 2027 – December 31, 2027

This booklet gives you 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, call us and ask for the *Evidence of Coverage*.

H3822_27PY4483897995_M 258038.0626

**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 a Customer Service representative at 1-877-774-8592 (TTY: 711). We are open 8 a.m. – 8 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on the weekends and holidays.

**Understanding the Benefits**

- ☐ Review the full list of benefits found in the *Evidence of Coverage* (EOC), especially for those services for which you routinely see a doctor. Call Customer Service at 1-877-774-8592 (TTY: 711) to request a copy of the EOC.
- ☐ Review the *Provider Finder* (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**

- ☐ 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.
- ☐ 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/co-insurance may change on January 1, 2028.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for certain covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.

# 1 SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

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, call us and ask for the *Evidence of Coverage*. Members can also see the *Evidence of Coverage* on our website, getblueil.com/mapd.

## You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Blue Cross Medicare Advantage Basic (HMO-POS)**).

## Tips for comparing your Medicare choices

This *Summary of Benefits* booklet gives you a summary of what **Blue Cross Medicare Advantage Basic (HMO-POS)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their *Summary of Benefits* booklets. Or, use the Medicare Plan Finder on https://www.medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at https://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

## Sections in this booklet

- Things to Know About **Blue Cross Medicare Advantage Basic (HMO-POS).**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services.
- Covered Medical and Hospital Benefits.
- Prescription Drug Benefits.

This document is available in other formats such as Braille, large print, or audio.

This document may be available in a non-English language. For additional information, call us at 1-877-774-8592 (TTY: 711).

## Things to Know About Blue Cross Medicare Advantage Basic (HMO-POS)

## Hours of Operation & Contact Information

- From October 1 to March 31, we are open 8 a.m. – 8 p.m., local time, 7 days a week.
- From April 1 to September 30, we are open 8 a.m. – 8 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays.
- If you are a member of this plan, call us at 1-877-774-8592, (TTY: 711).
- If you are not a member of this plan, call us at 1-877-213-1817, (TTY: 711).
- Our website: getblueil.com/mapd.

## Who can join?

To join **Blue Cross Medicare Advantage Basic (HMO-POS)**, 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 these counties in Illinois: Cook, DuPage, Kane and Will.

## Which doctors, hospitals, and pharmacies can I use?

**Blue Cross Medicare Advantage Basic (HMO-POS)** has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's *Provider Finder* and *Pharmacy Directory* at our website (getblueil.com/mapd).

Or, call us at 1-877-774-8592 (TTY: 711) and we will send you a copy of the *Provider Directory* and *Pharmacy Directory*.

## What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers – and more. Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs including chemotherapy and some drugs administered by your provider.

- You can see the complete plan *Formulary* (list of Part D prescription drugs) and any restrictions on our website, getblueil.com/mapd.
- Or, call us at 1-877-774-8592 (TTY: 711) and we will send you a copy of the *Formulary*.

## How will I determine my drug costs?

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Deductible, Initial Coverage and Catastrophic Coverage.

**If you have any questions about this plan's benefits or costs, please contact Blue Cross and Blue Shield of Illinois**

# 2 SECTION II - SUMMARY OF BENEFITS

**Blue Cross Medicare Advantage Basic (HMO-POS)**

| MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES | |
|---|---|
| **Monthly Plan Premium** | You pay $29 per month. In addition, you must keep paying your Medicare Part B premium. |
| **Part B Premium Buy-down (if applicable)** | This plan does not have a Part B Premium Buy-down. |
| **Deductible** | This plan does not have a deductible. |
| **Maximum Out-of-Pocket Responsibility** | 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.<br>Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.<br>Your yearly limit(s) in this plan:<br>• $5,500 for services you receive from in-network providers.<br>• No maximum out-of-pocket amount for services you receive from out-of-network providers. |
| **COVERED MEDICAL AND HOSPITAL BENEFITS** | |
| **Inpatient Hospital** | **In-Network:**<br>Days 1-7: $250 copay per day.<br>Days 8-90: $0 copay per day.<br>$0 copay per day for days 91 and beyond.<br>**Out-of-Network:**<br>Not Covered. |

| | |
|---|---|
| **Outpatient Hospital** | **<u>In-Network:</u>**<br>$0 - $300 copay.<br>**<u>Out-of-Network:</u>**<br>Not Covered. |
| **Ambulatory Surgical Center** | **<u>In-Network:</u>**<br>$0 - $275 copay.<br>**<u>Out-of-Network:</u>**<br>Not Covered. |
| **Doctor's Office Visits** | **<u>In-Network:</u>**<br>Primary care physician visit: $0 copay.<br>Specialist visit: $20 copay.<br>**<u>Out-of-Network:</u>**<br>Primary care physician visit: Not Covered.<br>Specialist visit: Not Covered. |
| **Preventive Care** ***(e.g., flu vaccine, diabetic screenings)*** | **<u>In-Network:</u>**<br>$0 copay for all preventive services covered under Original Medicare at zero cost sharing.<br>**<u>Out-of-Network:</u>**<br>Not Covered.<br>Other preventive services are available. There are some covered services that have a cost. Please reference the EOC for more details.<br>**Important Message About What You Pay for Vaccines**<br>Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Customer Service for more information. |
| **Emergency Care** | $130 copay per visit.<br>Worldwide Emergency Coverage: $130 copay. $50,000 yearly maximum coverage amount.<br>Copay is waived if you are admitted to the hospital within 24 hours for the same condition. See the "Inpatient Hospital" section of this booklet for other costs. |

| | |
|---|---|
| **Urgently Needed Services** | $50 copay per visit.<br>Worldwide Urgent Coverage: $130 copay. $50,000 yearly maximum coverage amount. |
| **Diagnostic Services /Labs/Imaging** | **In-Network:**<br>Diagnostic tests and procedures: $0 - $50 copay.<br>Lab services: $0 - $50 copay.<br>Diagnostic Radiology Services (such as MRIs, CT scans): $0 - $250 copay.<br>X-rays: $0 - $100 copay.<br>Therapeutic radiology services (such as radiation treatment for cancer): 20% of the total cost.<br>**Out-of-Network:**<br>Diagnostic tests and procedures: Not Covered.<br>Lab services: Not Covered.<br>Diagnostic Radiology Services (such as MRIs, CT scans): Not Covered.<br>X-rays: Not Covered.<br>Therapeutic radiology services (such as radiation treatment for cancer): Not Covered. |
| **Hearing Services** | **In-Network:**<br>Exam to diagnose and treat hearing and balance issues: $20 copay.<br>Routine hearing exam (1 every year): $0 copay.<br>Hearing aid fitting/evaluation: $0 copay.<br>Hearing aids: Benefit is limited to the TruHearing® branded hearing aids. $699 copay per Advanced aid or $999 copay per Premium aid (1 per ear per year).<br>**Out-of-Network:**<br>Exam to diagnose and treat hearing and balance issues: Not Covered. |
| **Dental Services** | **In-Network:**<br>Medicare-covered: $20 copay.<br>**Out-of-Network:**<br>Medicare-covered: 50% of the total cost. |

| | |
|---|---|
| | **<u>In-Network and Out-of-Network:</u>**<br>**Preventive Dental Services:**<br>• Oral exam (2 every year): $0 copay<br>• Cleaning (2 every year): $0 copay<br>• Dental X-ray (1 every year): $0 copay<br>**Comprehensive Dental Services:**<br>• $750 annual maximum coverage for preventive and basic restorative dental services. For more details on benefits and limitations regarding your dental coverage, please read your *Evidence of Coverage*. |
| **Vision Services** | **<u>In-Network:</u>**<br>**<u>Medicare-covered:</u>**<br>• Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $0 - $20 copay for an eye exam; $0 - $20 copay for one vision specialist exam<br>• Eyeglasses or contact lenses after cataract surgery: $0 copay<br>**<u>Routine Vision:</u>**<br>• Routine eye exam (1 every year): $0 copay<br>• Eyewear: $0 copay<br>• $100 yearly eyewear allowance maximum (eyewear includes: eyeglasses, frames, lenses, or contact lenses)<br>**<u>Out-of-Network:</u>**<br>**<u>Medicare-covered:</u>**<br>• Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): Not Covered<br>• Eyeglasses or contact lenses after cataract surgery: Not Covered |
| **Mental Health Services** | **<u>In-Network:</u>**<br>Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.<br>The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you are admitted as an |

| | |
|---|---|
| | inpatient and ends when you have not received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods.<br>Inpatient Mental Health Care:<br>Days 1-7: $250 copay per day.<br>Days 8-90: $0 copay per day.<br>Outpatient group therapy visit: $30 copay.<br>Outpatient individual therapy visit: $30 copay.<br>**Out-of-Network:**<br>Inpatient Mental Health Care: Not Covered.<br>Outpatient group therapy visit: Not Covered.<br>Outpatient individual therapy visit: Not Covered. |
| **Skilled Nursing Facility (SNF)** | **In-Network:**<br>Days 1-20: $10 copay per day.<br>Days 21-39: $221 copay per day.<br>Days 40-100: $0 copay per day.<br>**Out-of-Network:**<br>Not Covered. |
| **Physical Therapy** | **In-Network:**<br>$20 copay.<br>**Out-of-Network:**<br>Not Covered. |
| **Outpatient Rehabilitation** | **In-Network:**<br>Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): $40 copay.<br>Occupational therapy visit: $50 copay.<br>**Out-of-Network:**<br>Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): Not Covered |

| | |
|---|---|
| | Occupational therapy visit: Not Covered. |
| **Ambulance** | Ground Ambulance: $250 copay for each one-way trip.<br>Air Ambulance: 20% of the total cost for each one-way trip.<br>Worldwide Emergency Transportation: 20% of the total cost. $50,000 yearly maximum coverage. |
| **Transportation** | Not Covered |
| **Medicare Part B Drugs** | **In-Network:**<br>For Part B drugs such as chemotherapy drugs: 0 - 20% of the total cost.<br>Other Part B drugs: 0 - 20% of the total cost.<br>For Part B Insulin Drugs: 0 - 20% of the total cost with a maximum copay amount per month of $35.<br>**Out-of-Network:**<br>For Part B drugs such as chemotherapy drugs: Not Covered.<br>Other Part B drugs: Not Covered.<br>For Part B Insulin Drugs: Not Covered. |

<table>
<tr><th colspan="2">PRESCRIPTION DRUG BENEFITS</th></tr>
<tr><td>Deductible</td><td>Prescription Drug Deductible: $500 for Tiers 3, 4 and 5.<br>Once you have paid $500 for your Tiers 3, 4 and 5 drugs, you leave the Deductible Stage and move on to the next drug payment stage, which is the Initial Coverage Stage.<br>Important Message About What You Pay for Insulin<br>You won’t pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven’t paid your deductible.</td></tr>
<tr><td>Initial Coverage</td><td>You pay the following until your yearly out-of-pocket drug costs reach $2,400.
<table>
<tr><th colspan="3">Retail Cost-Sharing</th></tr>
<tr><th>Tier</th><th>One-month supply</th><th>Three-month supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$0 copay</td><td>$0 copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$1 copay</td><td>$3 copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>25% coinsurance</td><td>25% coinsurance</td></tr>
<tr><td>Tier 4 (Non-Preferred Drug)</td><td>25% coinsurance</td><td>25% coinsurance</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>28% coinsurance</td><td>Not Applicable</td></tr>
<tr><th colspan="3">Mail Order</th></tr>
<tr><th>Tier</th><th>One-month supply</th><th>Three-month supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$0 copay</td><td>$0 copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$1 copay</td><td>$2 copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>25% coinsurance</td><td>25% coinsurance</td></tr>
<tr><td>Tier 4 (Non-Preferred Drug)</td><td>25% coinsurance</td><td>25% coinsurance</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>28% coinsurance</td><td>Not Applicable</td></tr>
</table>
If you reside in a long-term care facility, you pay the same as at a retail pharmacy. We cover prescriptions filled at out-of-network pharmacies in only limited situations.<br>Please call us or see the plan’s Evidence of Coverage on our website (getblueil.com/mapd) for complete information about your costs for covered drugs.</td></tr>
</table>

| | |
|---|---|
| **Catastrophic Coverage** | After your yearly out-of-pocket drug costs reach $2,400, you pay nothing for covered Part D drugs. |

| Additional Member Benefits | Blue Cross Medicare Advantage Basic (HMO-POS)[SM] |
|---|---|
| **Acupuncture for Chronic Low Back Pain** | **In-Network:**<br>• $20 copay<br>**Out-of-Network:**<br>• Not Covered |
| **Chiropractic Care** | **Medicare-covered manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position).**<br>**In-Network:**<br>• $15 copay<br>**Out-of-Network:**<br>• Not Covered |
| **Diabetes Supplies and Services**<br>- Diabetes Monitoring Supplies<br>- Diabetes self-management training<br>- Therapeutic shoes or inserts<br>- Diabetic Monitors | **In-Network:**<br>**Diabetes monitoring supplies**<br>• 0 - 20% of the total cost<br>**Diabetes self-management training**<br>• $0 copay<br>**Therapeutic shoes or inserts**<br>• 20% of the total cost<br>**Diabetic Monitors**<br>• 0% of the total cost for Preferred Monitors<br>• 20% of the total cost for Non Preferred Monitors<br>**Out-of-Network:**<br>**Diabetes monitoring supplies**<br>• Not Covered<br>**Diabetes self-management training** |

| Additional Member Benefits | Blue Cross Medicare Advantage Basic (HMO-POS)[SM] |
|---|---|
| | • Not Covered<br>**Therapeutic shoes or inserts**<br>• Not Covered<br>**Diabetic Monitors**<br>• Not Covered |
| **Durable Medical Equipment** ***(wheelchairs, oxygen, etc.)*** | **In-Network:**<br>• 20% of the total cost<br>**Out-of-Network:**<br>• Not Covered |
| **Wellness Programs** | $0 copay for SilverSneakers® Fitness Program<br>SilverSneakers can help you live a healthier, more active life through fitness and social connection. You are covered for a fitness benefit through SilverSneakers online and at participating locations.<br>You have access to a nationwide network of participating locations where you can take classes.<br>SilverSneakers is a registered trademark of Tivity Health, Inc.© 2026 Tivity Health, Inc. All rights reserved. |
| **Foot Care** ***(podiatry services)*** | **Medicare-covered foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.**<br>**In-Network:**<br>• $20 copay<br>**Out-of-Network:**<br>• Not Covered |
| **Home Health Care** | **In-Network:**<br>• $0 copay<br>**Out-of-Network:** |

| Additional Member Benefits | Blue Cross Medicare Advantage Basic (HMO-POS)[SM] |
|---|---|
| | • Not Covered |
| **Opioid Treatment Program Services** | **In-Network:**<br>• $20 copay<br>**Out-of-Network:**<br>• Not Covered |
| **Outpatient Substance Abuse Services** | **In-Network:**<br>**Group therapy visit**<br>• $20 copay<br>**Individual therapy visit**<br>• $20 copay<br>**Out-of-Network:**<br>**Group therapy visit**<br>• Not Covered<br>**Individual therapy visit**<br>• Not Covered |
| **Over-the-Counter Items** | Every three months, you'll receive an $50 allowance to spend on over-the-counter (OTC) medications and other health-related items. Those include aspirin, vitamins, toothpaste and more. Your OTC allowance is loaded on your Flexible Spending card, a preloaded debit card. Use it to buy plan-approved items at participating retailers (in-store and online). Or order from our OTC catalog for home delivery. If the Flexible Spending card cannot be used at checkout, an alternative reimbursement process is available. Unused quarterly allowance amounts will roll over into the next quarter. All funds expire at the end of the plan year or when you leave the plan.<br>For details, please read your *Evidence of Coverage*. |
| **Prosthetic Devices *(braces,*** | **In-Network:**<br>**Prosthetic devices** |

| Additional Member Benefits | Blue Cross Medicare Advantage Basic (HMO-POS)[SM] |
|---|---|
| ***artificial limbs, etc.)*** | • 20% of the total cost<br>**Related medical supplies**<br>• 20% of the total cost<br>**Out-of-Network:**<br>**Prosthetic devices**<br>• Not Covered<br>**Related medical supplies**<br>• Not Covered |
| **Meals** | Not Covered |
| **Renal Dialysis** | **In-Network:**<br>• 20% of the total cost<br>**Out-of-Network:**<br>• Not Covered |
| **Telehealth Services** | • $0 copay for urgent care visits through the HCSC telehealth vendor |
| **Hospice** | You pay nothing for hospice care from a Medicare-certified hospice provider. You may have to pay part of the total costs for drugs and respite care. Hospice care is covered outside of our plan. Please contact us for more details. |

| Optional Supplemental Benefits | Blue Cross Medicare Advantage Basic (HMO-POS)[SM] |
|---|---|
| **OSB Package**<br>○ Additional Monthly Premium | • You'll pay an additional $38.90 per month if purchased.<br>○ Dental: comprehensive major restorative services with a higher coverage amount. This amount can be used toward all covered dental services.<br>Please read your *Evidence of Coverage* for details. |

## DISCLAIMERS

This document is available in other alternate formats.

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 1-877-774-8592 (TTY: 711). Someone who speaks Spanish can help you. This is a free service.

**Blue Cross Medicare Advantage Basic** is a HMO-POS plan with a Medicare contract. Enrollment in **Blue Cross Medicare Advantage Basic** depends on contract renewal.

This information is not a complete description of benefits. Call 1-877-774-8592 (TTY: 711) for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.

You must continue to pay your Medicare Part B premium.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Out-of-network/non-contracted providers are under no obligation to treat Blue Cross and Blue Shield of Illinois 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 Customer Service number or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.

Health coverage is offered by Health Care Service Corporation.

HMO-POS provided by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), an Independent Licensee of the Blue Cross and Blue Shield Association. HCSC is a Medicare Advantage organization with a Medicare contract. Enrollment depends on contract renewal.

Premium, copays, coinsurance, and deductibles may vary based on the level of Extra Help you receive. Please contact the plan for further details.

Benefits, features and/or devices vary by plan/service area. Limitations, copayments, exclusions and restrictions may apply. Contact the plan for more information.

Limitations, copayments, exclusions and restrictions may apply. Individuals must live in the plan service area. Benefits vary by plan. Prior authorization and/or referrals are required for certain services.

## Non-Discrimination Notice

**Health Care Coverage Is Important For Everyone**

We do not discriminate on the basis of race, color, national origin (including limited English knowledge and first language), age, disability, or sex (as understood in the applicable regulation). We provide people with disabilities with reasonable modifications and free communication aids to allow for effective communication with us. We also provide free language assistance services to people whose first language is not English.

To receive reasonable modifications, communication aids or language assistance free of charge, please call us at 1-877-774-8592 (TTY: 711).

If you believe we have failed to provide a service, or think we have discriminated in another way, you can file a grievance with:

Office of Civil Rights Coordinator
Attn: Office of Civil Rights Coordinator
300 E. Randolph St., 35th Floor
Chicago, IL 60601

Phone: 1-855-664-7270 (voicemail)
TTY/TDD: 1-855-661-6965
Fax: 1-855-661-6960
Email: civilrightscoordinator@hcsc.com

You can file a grievance by mail, fax or email. If you need help filing a grievance, please call the toll-free phone number listed on the back of your ID card (TTY: 711).

You may file a civil rights complaint with the US Department of Health and Human Services, Office for Civil Rights, at:

US Dept of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201

Phone: 1-800-368-1019
TTY/TDD: 1-800-537-7697
Complaint Portal:
ocrportal.hhs.gov/ocr/smartscreen/main.jsf
Complaint Forms:
hhs.gov/civil-rights/filing-a-complaint/index.html

If you are a Medicare member, access your Non-Discrimination Notice at https://www.bcbsil.com/il/documents/medicare/mapd/2026/mapd-mli-il-2026.pdf

This notice is available on our website at bcbsil.com/legal-and-privacy/non-discrimination-notice.

Blue Cross Blue Shield of Illinois, A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-877-774-8592 (TTY: 711). Hours are 8 a.m. – 8 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays. Or speak to your provider.

| | |
|---|---|
| Español<br>Spanish | ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-877-774-8592 (TTY: 711) o hable con su proveedor. |
| العربية<br>Arabic | تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-877-774-8592 (TTY: 711) أو تحدث إلى مقدم الخدمة. |
| 中文<br>Chinese | 注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-877-774-8592（文本电话：711）或咨询您的服务提供商。 |
| Français<br>French | ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-877-774-8592 (TTY : 711) ou parlez à votre fournisseur. |
| Deutsch<br>German | ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-877-774-8592 (TTY: 711) an oder sprechen Sie mit Ihrem Provider. |
| ગુજરાતી<br>Gujarati | ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ સવના મૂલ્યે ઉપલબ્ધ છે. 1-877-774-8592 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો. |
| हिंदी<br>Hindi | ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएँ उपलब्ध हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयोगी सामाजिक उपकरण और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-877-774-8592 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें। |
| Italiano<br>Italian | ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'1-877-774-8592 (tty: 711) o parla con il tuo fornitore. |
| 한국어<br>Korean | 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-877-774-8592 (TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오. |
| Diné<br>Navajo | SHOOH: Diné bee yáníłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'į' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjį' 1-877-774-8592 (TTY: 711) hodíilnih doodago nika'análwo'í bich'į' hanidziih. |
| فارسی<br>Farsi | توجه: اگر [وارد کردن زبان] صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 1-877-774-8592 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود |

| | |
|---|---|
| Polski<br>Polish | UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-877-774-8592 (TTY: 711) lub porozmawiaj ze swoim dostawcą. |
| Русский<br>Russian | ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-877-774-8592 (TTY: 711) или обратитесь к своему поставщику услуг. |
| Tagalog<br>Tagalog | PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-877-774-8592 (TTY: 711) o makipag-usap sa iyong provider. |
| اردو<br>Urdu | توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ (TTY: 711) 1-877-774-8592 پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔" |
| Ελληνικά<br>Greek | ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες υποστήριξης στη συγκεκριμένη γλώσσα. Διατίθενται δωρεάν κατάλληλα βοηθήματα και υπηρεσίες για παροχή πληροφοριών σε προσβάσιμες μορφές. Καλέστε το 1-877-774-8592 (TTY: 711) ή απευθυνθείτε στον πάροχό σας. |
| Việt<br>Vietnamese | LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-877-774-8592 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn. |

# THANK YOU

## Connect with us

**Contact Information:** 1-877-774-8592, TTY: 711

**Organization Name:** Blue Cross and Blue Shield of Illinois

**Organization website:** getblueil.com/mapd

Intentionally left blank