

2027

Summary of Benefits



Health Choice Pathway

(HMO D-SNP)



Serving Apache, Coconino,
Gila, Maricopa, Mohave, Navajo,
Pinal, and Yavapai counties.



**BlueCross
BlueShield**
Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

**Health
Choice**

Health Choice Pathway (HMO D-SNP)

Summary of Benefits

January 1, 2027 – December 31, 2027

Health Choice Pathway (HMO D-SNP)

How to reach us:

You can call us 7 days a week, 8 a.m. to 8 p.m.
If you are a member of this plan, call toll-free:
1-800-656-8991, TTY: 711.

If you are not a member of this plan, call toll-free:
1-855-243-3935, TTY: 711.

Or visit our website: azblue.com/hcpathway

Health Choice Pathway 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 and pharmacy directory on our website azblue.com/hcpathway, or call us and we will send you a copy of the provider and pharmacy directories.

This booklet gives you a summary of what we cover and what you pay. It doesn't 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" (EOC). You may access our EOC on our website at azblue.com/hcpathway.

Who can join?

To join Health Choice Pathway, you must be entitled to Medicare Part A, be enrolled in Medicare Part B and Arizona Health Care Cost Containment System (AHCCCS), and live in our service area. Our service area includes the following counties in Arizona: Apache, Coconino, Gila, Maricopa, Mohave, Navajo, Pinal, and Yavapai.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers – and more. Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits. Some of the extra benefits are outlined in this booklet. We cover Part D drugs. In addition, we cover Part B drugs such as 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 azblue.com/hcpathway, or call us and we will send you a copy of the formulary.

Which doctors, hospitals, and pharmacies can I use?

Health Choice Pathway 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 can see our plan's provider directory, pharmacy directory, and formulary on our website: azblue.com/hcpathway, or you can call us and we will send you a copy of the provider and pharmacy directories and/or formulary.

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

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 Health Choice Pathway.

You have choices.
Tips for comparing Medicare plans:

This Summary of Benefits booklet gives you a summary of what Health Choice Pathway 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 booklet or use the Medicare Plan Finder on <http://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 <http://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**.

Health Choice Pathway (HMO D-SNP) is a health plan with a Medicare contract and a contract with the state Medicaid program. Enrollment in Health Choice Pathway (HMO D-SNP) depends on contract renewal.

Health Choice Pathway is a subsidiary of Blue Cross® Blue Shield® of Arizona, an independent licensee of the Blue Cross Blue Shield Association.

This information is available in other formats, such as Braille, large print, and audio.

This information is not a complete description of benefits. **Call 1-800-656-8991, TTY: 711** for more information.

Health Choice Pathway 2027 Summary of Benefits Chart

If you lose your AHCCCS (Medicaid) eligibility but are expected to qualify again within 6 months, you will continue to receive all Medicare-covered benefits through our plan. However, your Medicaid benefits and help with Medicare premiums, copays, coinsurance, or deductibles may stop during this time, which could increase your out-of-pocket costs.

For more information, call Member Services at **1-800-656-8991, TTY: 711**.

Monthly Premium, Deductibles, and Limits	
Monthly Health Plan Premium	\$0
Annual Medical Deductible	This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility (this does not include prescription drugs)	If you lose your AHCCCS eligibility, the yearly maximum you will pay Health Choice Pathway (your maximum out-of-pocket amount) is \$9,850. If this occurs and you pay the full maximum out-of-pocket amount, we will pay for all Part A and B services for the rest of the year.

Covered Medical and Hospital Benefits

Inpatient Hospital Coverage

Prior authorization may be required	You pay \$0 copay for days 1 – 90 of a hospital stay per benefit period. Our plan also covers 60 lifetime reserve days, which can be used after day 90 if additional inpatient care is needed. After all lifetime reserve days are exhausted, you are responsible for all costs.
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Outpatient Hospital Coverage

Outpatient Hospital Prior authorization may be required	\$0 copay
Outpatient Hospital Observation Services Prior authorization may be required	\$0 copay
Ambulatory Surgery Center Prior authorization may be required	\$0 copay

Doctor Visits

Primary Care Provider Services	\$0 copay
Physician Specialists Services Prior authorization for pain management may be required	\$0 copay

Covered Medical and Hospital Benefits

Preventive Care

Abdominal aortic aneurysm screening	\$0 copay
Alcohol misuse screenings & counseling	
Annual wellness visit	
Bone mass measurements	
Breast cancer screening (mammogram)	
Cardiovascular disease (behavioral therapy)	
Cardiovascular disease screening (blood tests)	
Cervical and vaginal cancer screening (pap and pelvic exam)	
Colorectal cancer screenings (blood-based biomarker tests, colonoscopies, computed tomography (CT) colonography, fecal occult blood tests, flexible sigmoidoscopies, multi-target stool DNA tests)	
Counseling to prevent tobacco use & tobacco-caused disease	
Depression screenings	
Diabetes screenings	
Diabetes self-management training	
Glaucoma screening	
Hepatitis B vaccine and administration	
Hepatitis B virus screening	
Hepatitis C virus screening	
Human immunodeficiency virus (HIV) screening	
Initial Preventive Physical Examination (IPPE)	
Lung cancer screening (low-dose computed tomography (CT) scan)	
Medical nutrition therapy services	
Medicare Diabetes Prevention Program	
Obesity screening and behavioral therapy	
Prolonged preventive services	
Prostate cancer screening	
Sexually transmitted infections screenings & counseling	
Vaccines (COVID-19 vaccines, flu shots, pneumococcal shots)	
"Welcome to Medicare" preventive visit (one-time)	

Covered Medical and Hospital Benefits	
Emergency Care Services	
Emergency Care	\$0 copay for Medicare-covered emergency room visits
Urgently Needed Services	
Urgent Care	\$0 copay for Medicare-covered urgently needed services
Diagnostic Services/Labs/Imaging Lab Services	
Diagnostic tests and procedures Prior authorization may be required	\$0 copay
Lab services Prior authorization may be required	\$0 copay
Diagnostic radiology (e.g., MRI, CT) Prior authorization may be required	\$0 copay
Outpatient X-rays	\$0 copay
Therapeutic radiology Prior authorization may be required	\$0 copay
Hearing Services	
Medicare-covered diagnostic hearing and balance exams They're covered only when your doctor or other healthcare provider orders them to see if you need medical treatment.	\$0 copay
Routine Hearing Exam (Supplemental Benefit)	\$0 copay One exam per year
Hearing Aid Fitting and Hearing Aid (Supplemental Benefit) Services are covered through TruHearing® providers. Includes hearing aid fitting and evaluation. To schedule an appointment or ask questions, call 1-833-723-1154 , TTY: 711 , Monday – Friday 8 a.m. to 8 p.m. MST.	\$0 copay for hearing aid fitting \$0 copay for hearing aids Up to two hearing aids (one per ear, every 3 years)
Dental Services	
Medicare-covered dental services Medicare Part A (Hospital Insurance) will pay for certain dental services that you get when you're in a hospital. Part A can pay for inpatient hospital care if you need to have emergency or complicated dental procedures, even though the dental care isn't covered.	\$0 copay

Covered Medical and Hospital Benefits

Dental Services (continued)

Diagnostic, Preventive, and Comprehensive Dental (Supplemental Benefit)

Diagnostic and preventive dental services including:

- One Fluoride Treatment every year
- Two Oral Exams every year
- Two Prophylaxis (Cleanings) every year, once every 6 months
- Two Dental X-rays every year, which can consist of:
 - Either two bite-wing X-rays or
 - One complete set—also known as a full-mouth (FMX) set or a panoramic X-ray. A complete set/panoramic X-ray is only permitted once every 36 months.

Comprehensive dental services including:

- Restorative services – Crowns, fillings, and bridges used to restore damaged teeth or replace a single missing tooth.
- Endodontics services – Root canal therapy and treatment for cracked or severely damaged teeth.
- Periodontics services – Deep cleanings, treatment of gum infections, and management of gingivitis and periodontitis.
- Oral and maxillofacial surgery – Tooth extractions, treatment of jaw infections, cyst removal.
- Prosthodontics – Fixed and removable dental prostheses.
 - Fixed prosthodontics – Restorations that stay in your mouth and are not removed such as crowns and bridges.
 - Removable prosthodontics – Dentures and partial dentures.
 - Dentures are covered once every five years. Complete and partial dentures share this same five-year limit.
- Adjunctive General Services – Diagnostic X-rays, emergency dental examinations, and sedation when medically necessary.

Not covered:

- Certain Prosthodontics procedures including dental and facial cosmetic restoration
- Dental implants
- Temporomandibular Joint (TMJ) Restorative procedures

\$0 copay for dental services (supplemental)

\$2,000 maximum benefit allowance per calendar year for diagnostic and preventive dental services and comprehensive dental services

Covered Medical and Hospital Benefits

Vision Services

Medicare-covered vision exam to diagnose/treat diseases of the eye (including yearly glaucoma screening) Eyeglasses or contact lenses after cataract surgery	\$0 copay
Routine Eye Exam (eye refraction) (Supplemental Benefit)	\$0 copay One every year
Eyewear (Supplemental Benefit)	\$0 copay Our plan pays up to \$250 maximum benefit allowance every year for unlimited eyewear • Contact Lenses • Eyeglasses (frames and lenses)

Covered Medical and Hospital Benefits

Mental Health Services

Inpatient Hospital Psychiatric Prior authorization may be required	You pay \$0 copay for days 1 – 90 of a hospital stay per benefit period. Our plan also covers 60 lifetime reserve days, which can be used after day 90 if additional inpatient care is needed. After all lifetime reserve days are exhausted, you are responsible for all costs.
Outpatient Individual/Group Therapy Visit • Mental Health Specialty Service • Psychiatric Services • Substance Abuse	\$0 copay
Intensive Outpatient Program Services	\$0 copay

Skilled Nursing Facility

Prior authorization may be required	You pay \$0 copay for days 1 – 100 of a skilled nursing facility stay.
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Outpatient Blood Services

Outpatient Blood Services (Supplemental Benefit)	\$0 copay First three (3) pints of blood deductible is waived. Coverage of whole blood and packed red cells begins with the first pint of blood that you need.
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Outpatient Rehabilitation

Physical Therapy and Speech Therapy Services Prior authorization may be required	\$0 copay
Cardiac and Pulmonary Rehabilitation	\$0 copay
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.	\$0 copay
Occupational Therapy Services Prior authorization may be required	\$0 copay

Covered Medical and Hospital Benefits	
Ambulance	
Prior authorization required for non-emergent ambulance only	\$0 copay for ground and air ambulance services
Transportation	
This benefit is available to help you obtain medically necessary care and services. Covered Services include: • Curb-to-curb service • Wheelchair-accessible vans upon request • Each one-way trip must not exceed 50 miles. A trip is considered one way, a round trip is considered two trips Covered Services do not include: • Transportation by ambulance	\$0 copay 24 one-way trips every year to or from approved location
Prescription Drug Benefits	
Medicare Part B Drugs	
Chemotherapy/radiation drugs Prior authorization may be required	\$0 copay Medicaid (AHCCCS) generally covers your Medicare cost sharing. However, you may be responsible for up to 20% of the Medicare-approved amount for any items or services that are not covered by AHCCCS.
Other Medicare Part B drugs Prior authorization may be required Medicare Part B drugs – Step Therapy	\$0 copay For covered insulin furnished under Medicare Part B (such as insulin used with an insulin pump), you pay \$0 copayment as long as you maintain full AHCCCS (Medicaid) eligibility. If you lose AHCCCS (Medicaid) eligibility, you may be responsible for Medicare Part B cost sharing. However, your cost sharing for covered Part B insulin will not exceed \$35 for a one-month supply. Step Therapy for Part B drugs may require a trial of a Part B or Part D drug.

Prescription Drug Benefits

Part D Benefit

Medicare-covered only

If you qualify for Low-Income Subsidy (LIS), your cost sharing for formulary Part D drugs is reduced or waived, depending on your income and AHCCCS (Medicaid) eligibility. The following copayments apply for LIS-eligible members:

Initial Coverage stage: During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost. Your yearly deductible is \$0 or \$300. Your cost-sharing amounts for drugs are:

	Generic/Treated as generic drugs, per prescription (retail or mail order pharmacy, 31-day or 100-day supply, Long-term care (LTC) cost sharing, 34-day supply.)	Brand name drugs, per prescription (retail or mail order pharmacy, 31-day or 100-day supply, Long-term care (LTC) cost sharing, 34-day supply.)
Institutionalized Members	\$0	\$0
Full Benefit Dual Eligible (FBDE) members up to or 100% Federal Poverty Level (FPL)	\$1.65	\$5.00
Full Benefit Dual Eligible (FBDE) members between 100% and 150% Federal Poverty Level (FPL)	\$5.80	\$14.40
QMB/QMB+/SLMB+ members at or below 150% Federal Poverty Level (FPL)	\$5.80	\$14.40
If you do not receive “Extra Help” or lose your Low Income Subsidy (LIS) eligibility, the amount you pay will change to Original Medicare levels. These copay amounts are only for in-network pharmacies. You may get your drugs at in-network retail and mail-order pharmacies. You may be able to get a 100-day supply of your prescription (if your drug is applicable).		

You stay in this stage until the amount of your year-to-date “out-of-pocket costs” reaches \$2,400. You then move to the Catastrophic Coverage stage. Catastrophic Coverage stage: During this stage, Health Choice Pathway will pay all of the costs of your drugs until 12/31/2027. On 1/1/2028, you go back to the Initial Coverage stage.

Important Message About What You Pay for Vaccines

Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.

Important Message About What You Pay for Insulin

For covered insulin furnished under Medicare Part B (such as insulin used with an insulin pump), you pay \$0 as long as you maintain full AHCCCS (Medicaid) eligibility. If you lose AHCCCS eligibility, you may be responsible for Medicare Part B cost sharing. However, your cost sharing for covered Part B insulin will not exceed \$35 for a one-month supply.

Additional Covered Benefits	
Services to Treat Kidney Disease	
• Kidney disease education services	\$0 copay
• Dialysis services	\$0 copay
• Home dialysis equipment and supplies	
Annual Physical Exam (Supplemental)	
The annual routine physical is an extensive physical exam including a medical history collection and it may also include any of the following: vital signs, observation of general appearance, a head and neck exam, a heart and lung exam, an abdominal exam, a neurological exam, a dermatological exam, and an extremities exam. Coverage for this non-Medicare covered benefit is in addition to the Medicare-covered annual wellness visit and the “Welcome to Medicare” preventive visit.	\$0 copay
Chiropractic Services	
Medicare-covered Manipulation of the spine to correct a subluxation (when one or more of the bones of your spine move out of position) Prior authorization may be required	\$0 copay
Home Health Care	
Prior authorization may be required	\$0 copay
Opioid Treatment Program Services (OTPS)	
• FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable • Substance use counseling • Individual and group therapy • Toxicology testing	\$0 copay
Podiatry Services (Foot Care)	
Medicare-covered Foot Exam and Treatment Foot exams and treatment if you have diabetes-related nerve damage and/or meet conditions Prior authorization may be required	\$0 copay

Additional Covered Benefits	
Medical Equipment/Supplies	
Durable Medical Equipment (DME) (e.g., wheelchairs, oxygen) Prior authorization may be required	\$0 copay
Prosthetics/Medical Supplies Prior authorization may be required	\$0 copay
Diabetic Supplies and Services Prior authorization applies only to insulin pumps and not regular supplies (lancet, strips)	\$0 copay Medicaid (AHCCCS) generally covers your Medicare cost sharing. However, you may be responsible for up to 20% of the Medicare-approved amount for any items or services that are not covered by AHCCCS.
Therapeutic shoes or inserts for people with diabetes	\$0 copay

Additional Covered Benefits

Additional Supplemental Benefits

Fitness Membership

\$0 copay for physical fitness, activity tracker, fitness equipment, or kit. SilverSneakers® is more than a traditional fitness program. It's a way to improve your health and live the life you want. Whether you enjoy group fitness classes, sports, or using strength and cardio equipment, or prefer staying active at home, SilverSneakers gives you the opportunity to improve your health, gain confidence, and connect with your community.

SilverSneakers gives you access to:

- A nationwide network of participating gym and community locations¹ with group fitness classes² at select locations - enroll in as many as you'd like
- SilverSneakers LIVE online classes and workshops led by specially trained instructors, offered 7 days a week, morning, afternoon, and evening
- SilverSneakers On-Demand 200+ online workout videos available 24/7
- SilverSneakers GO mobile app with adjustable workout plans and more
- Free At-Home kits are available for members, who can choose one kit per year (four options to choose from). Each kit includes a quick start guide. The at-home kits* available include:
 - o Walking: includes a pedometer
 - o Toning: includes a SilverSneakers ball
 - o Strength: includes a resistance band
 - o Yoga: includes a yoga strap

With SilverSneakers, you have more options than ever. Activate your free online account today and explore everything SilverSneakers has to offer.

[SilverSneakers.com/StartHere](https://www.silversneakers.com/StartHere)

tools.silversneakers.com/Eligibility/StartHere

Always talk with your doctor before starting an exercise program.

Footnotes:

¹ Participating locations ("PL") are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL. Inclusion of specific PLs is not guaranteed and PL participation may differ by health plan.

² Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location.

*Contents of kits may change without notice.

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Additional Covered Benefits

Additional Supplemental Benefits

Over-the-Counter (OTC)

The quarterly allowance can be utilized to purchase OTC items either online through catalog purchase or in-store at participating retailers using the flex debit card.

\$0 copay for \$50 every three months allowance for OTC products.

With this benefit, the allowance will be loaded to your Flex Card every three months to pay for covered OTC items.

Covered items include:

- Brand-name and generic OTC products, such as vitamins, pain relievers, toothpaste, cough drops, and more.

To place an order, check your card balance, browse eligible OTC items, or find participating store locations, visit **azblue.com/hcpathway/extrabenefits**.

Any remaining allowance at the end of the quarter will expire and does not roll over to the next month. Any unused allowance will not carry over to the next plan year.

Please refer to Chapter 4 of the Evidence of Coverage (EOC) for more detailed information.

Meal Benefit

Prior authorization may be required

\$0 copay up to 56 total meals per year to members who have been discharged from an inpatient facility or have an eligible chronic health condition.

Post-Acute Meals - 28 meals per admit:

Members recently discharged from an inpatient facility (Hospital, Skilled Nursing Facility, or Inpatient Rehabilitation).

Chronic Meals - 28 meals per admit:

Members with an eligible chronic condition who are under care management may be eligible to receive healthy meals. Eligible chronic conditions include: chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), diabetes (DM).

Additional Covered Benefits	
24-Hour Nurse Advice Line 1-888-267-9037 24/7 access to registered nurse	\$0 copay
Additional Supplemental Benefits	
Telehealth	\$0 copay for Telehealth Services Covered services included in Virtual Medical Visits: • Primary Care Provider Services • Physician Specialist Services • Urgently Needed Services Get care for certain non-emergency health concerns through telehealth at no cost. Telehealth visits are available 24 hours a day, 7 days a week with a licensed provider using your phone, tablet, or computer. Access telehealth through the Health Choice Arizona Member Portal: azblue.com/hcportal Not all medical conditions can be treated through telehealth. If additional care is needed, the provider will let you know if you should see an in-person doctor. If you have a medical emergency, call 911 or go to the nearest emergency room right away.
Personal Emergency Response System (PERS)	\$0 copay Personal emergency response system (PERS), also known as medical alert systems, provide continuous in-home and mobile monitoring to aging and at-risk populations. PERS allows members to call for assistance 24/7, whether at home or on the go. • Members are immediately connected with professionally trained operators who quickly assess the nature of a call and coordinate appropriate assistance. • A member experiencing a medical emergency presses a button to speak with an operator who immediately coordinates emergency dispatch. To order a PERS device or for additional questions, call 1-800-979-9238, TTY: 711, 8 a.m. to 5 p.m., Monday through Friday or visit bcbsaz.connectamerica.com.

Additional Covered Benefits

Special Supplemental Benefits for the Chronically Ill

Healthy Food and Produce

\$0 copay for \$225 allowance every three months for Healthy Food and Produce.

This benefit is offered as part of the Special Supplemental Benefits for the Chronically Ill (SSBCI) and is only available to members who meet plan eligibility requirements.

To qualify for the Healthy Food and Produce benefit, you must:

- Be under the care of a treating provider and diagnosed with one or more qualifying chronic conditions and a claim on file with Health Choice Pathway.
- Have a high risk of hospitalization or other adverse health outcomes.

Qualifying chronic conditions include:

Cardiovascular disorders, chronic alcohol use disorder and other substance use disorders (SUDs), chronic and disabling mental health conditions, chronic gastrointestinal disease, chronic heart failure, chronic lung disorders, conditions that impair vision, hearing (including deafness), taste, touch, or smell, conditions that require continued therapy services to maintain or retain functioning, diabetes mellitus, and overweight, obesity, and metabolic syndrome.

The benefits mentioned are part of a special supplemental program for the chronically ill. Not all members qualify, as other coverage criteria may also apply.

To place an order, check your card balance, browse eligible healthy food and produce items, or find participating store locations, visit **azblue.com/hcpathway/extrabenefits**.

Unused allowance does not roll over to the next quarter. Allowance remaining at the end of the year does not carry over to the following plan year.

Please refer to Chapter 4 of the Evidence of Coverage (EOC) for more detailed information.

Summary of Medicaid-Covered Benefits

Your state Medicaid program can be reached through the office of the Arizona Health Care Cost Containment System (AHCCCS).

A person who is entitled to both Medicare and medical assistance from a state Medicaid plan is referred to as a “dual eligible” beneficiary. As a dual eligible beneficiary your services are paid first by Medicare and then by AHCCCS (Medicaid). Your AHCCCS (Medicaid) coverage varies depending on your income, resources, and other factors. Benefits may include full AHCCCS (Medicaid) benefits and/or payment of some or all of your Medicare cost share (premiums, deductibles, coinsurance, or copays). Depending on your level of AHCCCS (Medicaid) eligibility, you may not have any cost-sharing responsibility for Medicare-covered services.

Below is a list of dual eligibility coverage categories for beneficiaries who may enroll in the Health Choice Pathway Plan:

- **QMB-plus (or QMB+):** AHCCCS (Medicaid) pays your Medicare Part A and Part B premiums, deductibles, coinsurance, and copayment amounts. You receive Medicaid coverage of Medicare cost sharing and are eligible for full Medicaid benefits secondary to your Medicare coverage. This means if Medicare doesn't cover something, but Medicaid does, Medicaid will pay (as long as your provider is in-network).
- **SLMB-plus (or SLMB+):** AHCCCS (Medicaid) pays your Medicare Part B premium and also provides full Medicaid benefits secondary to your Medicare benefit.
- **Full-Benefit Dual Eligible (FBDE):** At times, individuals may qualify for both limited coverage of Medicare cost sharing as well as full AHCCCS (Medicaid) benefits.

If you are a QMB or QMB-plus Beneficiary:

You have a \$0 cost share, except for Part D prescription drug copays, as long as you remain a QMB or QMB+ Member.

If you are an SLMB-plus or FBDE Beneficiary:

You are eligible for full AHCCCS (Medicaid) benefits and, at times, limited Medicare cost share. As such, your cost share is 0% or 20%*. Typically your cost share is 0% when the service is covered by both Medicare and AHCCCS (Medicaid). Additionally, preventive wellness exams and supplemental benefits provided by Health Choice Pathway are also at a \$0 cost share. In rare instances, you will pay 20%* when a service or benefit is not covered by AHCCCS (Medicaid).

Note – Preventive wellness exams and supplemental benefits have a \$0 cost share.

Eligibility Changes:

It is important to read and respond to all mail that comes from Social Security and your state Medicaid office and to maintain your AHCCCS (Medicaid) eligibility status.

Periodically, as required by CMS, we will check the status of your AHCCCS (Medicaid) eligibility as well as your dual eligible category. If your eligibility status changes, your cost share may also change from 0% to 20% or from 20% to 0%. If you lose AHCCCS (Medicaid) coverage entirely, you will be given a grace period so that you can reapply for AHCCCS (Medicaid) and become reinstated if you still qualify.

If you no longer qualify for AHCCCS (Medicaid) you will be involuntarily disenrolled from the plan. Your state Medicaid agency will send you notification of your loss of AHCCCS (Medicaid)

or change in AHCCCS (Medicaid) category. We may also contact you to remind you to reapply for Medicaid. For this reason it is important to let us know whenever your mailing address and/or phone number changes.

If you are currently entitled to receive full or partial AHCCCS (Medicaid) benefits, please see your Medicaid member handbook or other state Medicaid documents for full details on your AHCCCS (Medicaid) benefits, limitations, restrictions, and exclusions. In your state, the Medicaid program can be reached through the office of the Arizona Health Care Cost Containment System (AHCCCS).

*Annual deductible for Part B services, and 20% coinsurance (as applicable), in addition to varying cost-share amounts for Part A services apply when Member’s cost-share amount is not 0%.

How to Read the Medicaid Benefit Chart

The chart below shows what services are covered by AHCCCS (Medicaid). The chart applies only if you are entitled to benefits under your state’s

Medicaid program. Your cost share varies based on your AHCCCS (Medicaid) category.

For Medicaid-covered services, refer to the AHCCCS plan or visit the website at **www.azahcccs.gov** for additional beneficiary cost sharing, copayment, and benefits-related information.

Acute Medicaid Programs include AHCCCS Complete Care (ACC), ACC Regional Behavioral Health Agreements (ACC-RBHAs), and the Mercy Care Department of Child Safety Comprehensive Health Plan (Mercy Care DCS CHP). Long Term Care Medicaid Programs include Elderly and Physically Disabled (E-PD) and Division of Developmental Disabilities (DDD).

Medicare Part D copayment amounts are the sole responsibility of the beneficiary. AHCCCS health plans cannot assist with the payment of these amounts, except for behavioral health medications for those beneficiaries determined to be Seriously Mentally Ill (SMI) utilizing allowable Non-Title XIX funding.

Medicaid-Covered Benefits Chart		
	As an Arizona Health Care Cost Containment System (AHCCCS) – QMB Dual Eligible – You Pay:	As an Arizona Health Care Cost Containment System (AHCCCS) – Non-QMB Dual Eligible – You Pay:
Important Information		
Premium and Other Important Information If you get Extra Help from Medicare, your monthly plan premium will be lower or you might pay nothing.	Medicaid assistance with premium payments and cost share may vary based on your level of AHCCCS (Medicaid) eligibility.	Medicaid assistance with premium payments and cost share may vary based on your level of AHCCCS (Medicaid) eligibility.
Doctor and Hospital Choice (For more information, see Emergency Care and Urgently Needed Care services.)	You must go to doctors, specialists, and hospitals that accept Medicaid assignment. Referral required for network specialists for certain benefits.	You must go to doctors, specialists, and hospitals that accept Medicaid assignment. Referral required for network specialists for certain benefits.

Acute and Long-Term Care Medicaid Programs		
	As an Arizona Health Care Cost Containment System (AHCCCS) – QMB Dual Eligible – You Pay:	As an Arizona Health Care Cost Containment System (AHCCCS) – Non-QMB Dual Eligible – You Pay:
Inpatient Care		
Inpatient Hospital Care	\$0 copay	\$0 copay
Inpatient Behavioral Health Care Stay	\$0 copay	\$0 copay
Nursing Facility Services	\$0 copay	\$0 copay
Outpatient Care Services		
Ambulance Services (Medically necessary ambulance services)	\$0 copay	\$0 copay
Ambulatory Surgical Center or Outpatient Hospital Facility Visit	\$0 copay	\$0 to \$3 copay depending on eligibility for ages 21 and over. \$0 copay for ages 20 and under.
Medicare-Covered Services, including Chronic/Complex Case Management, etc.	\$0 copay	\$0 copay for ages 20 and under. Not covered for ages 21 and over.
Chiropractic Visits	\$0 copay	\$0 for ages 20 and under; \$0 to \$2.30, for ages 21 and over depending on eligibility, for up to 20 medically necessary visits beginning October 1st of each year (additional visits may be authorized if medically necessary)
Adult Emergency Dental Services	\$0 copay For ages 21 and over. Services subject to a \$1,000 limit per each 12-month period beginning October 1st of each year.	\$0 copay For ages 21 and over. Services subject to a \$1,000 limit per each 12-month period beginning October 1st of each year.
Diabetes Self-Monitoring Training & Supplies (when provided as part of a PCP visit)	\$0 copay	\$0 copay

Acute and Long-Term Care Medicaid Programs		
	As an Arizona Health Care Cost Containment System (AHCCCS) – QMB Dual Eligible – You Pay:	As an Arizona Health Care Cost Containment System (AHCCCS) – Non-QMB Dual Eligible – You Pay:
Outpatient Care Services		
Diagnostic Tests, X-rays, and Laboratory Services (including COVID-19 diagnostic & testing services)	\$0 copay	\$0 copay
Doctor Office Visits: Primary Care Provider (PCP) and Specialist Physician visits	\$0 copay	\$0 copay for well visits, and \$0 to \$4 for other visits depending on eligibility for ages 21 and over. \$0 copay for ages 20 and under.
Durable Medical Equipment (Includes wheelchairs, oxygen, etc.)	\$0 copay Covers reasonable and medically necessary medical equipment, appliances, and supplies.	\$0 copay Covers reasonable and medically necessary medical equipment, appliances, and supplies.
Emergency Services (You may go to any emergency room if you reasonably believe you need emergency care.)	\$0 copay	\$0 copay
Hearing Exams, Routine Hearing Tests, and Fitting Evaluations for a Hearing Aid	\$0 copay for ages 20 and under. Not covered for ages 21 and over.	\$0 copay for ages 20 and under. Not covered for ages 21 and over.
Hearing Aids	\$0 copay for ages 20 and under. Not covered for ages 21 and over.	\$0 copay for ages 20 and under. Not covered for ages 21 and over.
Cochlear Implants	\$0 copay	\$0 copay
Home Health Service (Such as nursing services, home health aide, and therapy.)	\$0 copay Covers medically necessary home health services within certain limits.	\$0 copay Covers medically necessary home health services within certain limits.
Outpatient Behavioral Health Care Visit	\$0 copay	\$0 copay
Outpatient Occupational Therapy, Physical/ Speech Therapy	\$0 copay	\$0 to \$3 copay depending on eligibility for ages 21 and over. \$0 copay for ages 20 and under.
Outpatient Substance Abuse Care	\$0 copay	\$0 copay
Podiatry Services	\$0 copay	\$0 copay

Acute and Long-Term Care Medicaid Programs		
	As an Arizona Health Care Cost Containment System (AHCCCS) – QMB Dual Eligible – You Pay:	As an Arizona Health Care Cost Containment System (AHCCCS) – Non-QMB Dual Eligible – You Pay:
Outpatient Care Services		
Prosthetic Devices (Includes braces, artificial limbs and eyes, etc.)	\$0 copay	\$0 copay Lower limb microprocessor controlled limb or joint not covered for ages 21 and over.
Non-Emergency Medically Necessary Transportation	\$0 copay	\$0 copay
Urgently Needed Care Visit	\$0 copay	\$0 to \$4 copay depending on eligibility for ages 21 and over. \$0 copay for ages 20 and under.
Vision Services, Routine Eye Exam, Eyeglasses, Contact Lenses, Lenses and Frames	\$0 copay for ages 20 and under. Not covered for ages 21 and over unless following cataract surgery.	\$0 copay for ages 20 and under. Not covered for ages 21 and over.
Renal Dialysis or Nutritional Therapy for End-Stage Renal Disease	\$0 copay	\$0 copay
Prescription Drug Benefits		
Prescription Medications	\$0 copay For medications not eligible for payment under Medicare Part D.	\$0 to \$2.30 copay depending on eligibility for ages 21 and over. \$0 copay for ages 20 and under. For medications not eligible for payment under Medicare Part D.
Preventive Services		
Including Flu, COVID-19, and Pneumonia Vaccines, Screening Mammogram, Pap Smear and Pelvic Exam, Prostate Cancer Screening, and Colorectal Screening.	\$0 copay	\$0 copay
Community Health Worker (CHW) Visit	\$0 copay	\$0 copay

Long-Term Care Medicaid Programs Only

Respite Services	\$0 copay Subject to a 600-hour limit per each 12-month period beginning October 1st of each year.	\$0 copay Subject to a 600-hour limit per each 12-month period beginning October 1st of each year.
Nursing Facility Services	Cost sharing determined by AHCCCS.	Cost sharing determined by AHCCCS.
Home and Community-Based Services	Member contribution determined by AHCCCS.	Member contribution determined by AHCCCS.
Adult Preventive Dental Services In addition to Adult Emergency Dental Services described above.	\$0 copay for ages 21 and over. Services subject to a \$1,000 limit per each 12-month period beginning October 1st of each year.	\$0 copay for ages 21 and over. Services subject to a \$1,000 limit per each 12-month period beginning October 1st of each year.

Glossary of Terms

Centers for Medicare & Medicaid Services (CMS)

The Federal agency that administers Medicare.

Coinsurance

An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services or prescription drugs after you pay any deductibles.

Copayment (or “copay”)

An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor’s visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount (for example \$10), rather than a percentage.

Cost Sharing

Cost sharing refers to amounts that a member has to pay when services or drugs are received. (This is in addition to the plan’s monthly premium.) Cost sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed “copayment” amount that a plan requires when a specific service or drug is received; or (3) any “coinsurance” amount, a percentage of the total amount paid for a service or drug that a plan requires when a specific service or drug is received.

Deductible

The amount you must pay for healthcare or prescriptions before our plan pays.

Extra Help

A Medicare or a State program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Maximum Out-of-Pocket Amount

The most that you pay out of pocket during the calendar year for covered Part A and Part B services. Amounts you pay for your plan premiums, Medicare Part A and Part B premiums, and prescription drugs do not count toward the maximum out-of-pocket amount.

If you are eligible for Medicare cost-sharing assistance under AHCCCS (Medicaid), you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. (Note: Because our members also get assistance from AHCCCS (Medicaid), very few members ever reach this out-of-pocket maximum.)

Medicaid (AHCCCS or Medical Assistance)

A joint Federal and State program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most healthcare costs are covered if you qualify for both Medicare and Medicaid.

Medicare

The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant) and Amyotrophic Lateral Sclerosis (ALS, also known as Lou Gehrig’s disease).

Glossary of Terms

Medicare Advantage (MA) Plan

Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called Medicare Advantage Plans with Prescription Drug Coverage.

Original Medicare (“Traditional Medicare” or “Fee-for-service” Medicare)

Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans.

Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other healthcare providers payment amounts established by Congress. You can see any doctor, hospital, or other healthcare provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share.

Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Part C

see “Medicare Advantage (MA) Plan.”

Part D

The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs

Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded from Part D coverage by Congress. Certain categories of Part D drugs must be covered by every plan.

Premium

The periodic payment to Medicare, an insurance company, or a healthcare plan for health or prescription drug coverage.

Prior Authorization

Approval in advance to get services or certain drugs. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4 of the “Evidence of Coverage”. Covered drugs that need prior authorization are marked in the formulary.

Special Needs Plan

A special type of Medicare Advantage Plan that provides more focused healthcare for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

Notice of Non-Discrimination

In Compliance with Section 1557 of the Affordable Care Act



Health
Choice

Health Choice Pathway HMO D-SNP complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes). Health Choice Pathway does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Health Choice Pathway:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact:

Health Choice Pathway
Attn: Civil Rights Coordinator
Address: PO Box 52033
Phoenix, AZ 85072
Phone: 1-800-656-8991, TTY: 711
8 a.m. to 8 p.m., 7 days a week
Fax: 480-760-4739
Email: HCHComments@azblue.com

If you believe that Health Choice Pathway has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes), you can file a grievance by mail, fax, or email to:

Health Choice Pathway
Attn: Civil Rights Coordinator
Address: PO Box 52033
Phoenix, AZ 85072
Phone: 1-800-656-8991
Fax: 480-760-4739
TTY: 711
Email: HCH.GrievanceForms@azblue.com

You can file a grievance by mail, fax, or email. If you need help filing a grievance, the Grievance Manager/Civil Rights Coordinator is available to help you.

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, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at
hhs.gov/hipaa/filing-a-complaint/index.html.

Aviso de No Discriminación

En cumplimiento con la Sección 1557 de la Ley de Cuidado de Salud de Bajo Costo



Health
Choice

Health Choice Pathway HMO D-SNP cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo (incluidas las características sexuales, los rasgos intersexuales, el embarazo o afecciones relacionadas, la orientación sexual, la identidad de género y los estereotipos sexuales). Health Choice Pathway no excluye ni trata a las personas de forma menos favorable por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Health Choice Pathway:

Ofrece material de ayuda y servicios sin cargo a las personas que tienen discapacidades que les impiden comunicarse de manera eficaz con nosotros, como los siguientes:

- Intérpretes de lenguaje de señas calificados
- Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos)

Brinda servicios de idiomas sin cargo a las personas cuya lengua materna no es el inglés, como los siguientes:

- Intérpretes calificados
- Información escrita en otros idiomas

Si necesita estos servicios, comuníquese con nosotros:

Health Choice Pathway
Coordinador de Derechos Civiles

Dirección: PO Box 52033

Phoenix, AZ 85072

Teléfono: 1-800-656-8991, TTY: 711

de 8 a.m. a 8 p.m., los 7 días de la semana

Fax: 480-760-4739

Correo electrónico:

HCHComments@azblue.com

Si considera que Health Choice Pathway no ha logrado prestar estos servicios o ha discriminado de algún otro modo a una persona por su raza, color, nacionalidad, edad, discapacidad o sexo (incluidas las características sexuales, los rasgos intersexuales, el embarazo o afecciones relacionadas, la orientación sexual, la identidad de género y los estereotipos sexuales), puede presentar una queja formal por correo, fax o correo electrónico:

Health Choice Pathway
Coordinador de Derechos Civiles

Dirección: PO Box 52033

Phoenix, AZ 85072

Teléfono: 1-800-656-8991

Fax: 480-760-4739

TTY: 711

Correo electrónico:

HCH.GrievanceForms@azblue.com

Puede presentar una queja formal por correo, fax o correo electrónico. Si necesita ayuda para presentar una queja formal, el administrador de quejas formales/coordinador de derechos civiles está a su disposición para ayudarlo.

También puede presentar una queja por violación a los derechos civiles ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de los EE. UU. de forma electrónica a través de su Portal de quejas, disponible en **<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>**, o por correo o teléfono:

U.S. Department of Health and Human Services
200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 1-800-537-7697 (TDD)

Los formularios de queja están disponibles en **hhs.gov/hipaa/filing-a-complaint/index.html**.

Health Choice Pathway es una subsidiaria de Blue Cross® Blue Shield® of Arizona, un licenciario independiente de Blue Cross Blue Shield Association.

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Notice of Availability of Language Assistance Services and Auxiliary Aids and Services



Health
Choice

English: 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 1-800-656-8991 (TTY: 711), 8 a.m. to 8 p.m., 7 days a week.

Spanish: 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 1-800-656-8991 (TTY: 711), de 8 a. m. a 8 p. m., los 7 días de la semana.

Navajo: Saad bee áká anályaaígíí t'áá jíík'eh bee nihá náshcháázhgo bee áká aná'ályáá doo bááh dah na'anish. Bee áká aná'ályáá dóo bee hane' bee nidaaz'áájí bee hazh'ání'íígo ádaat'éego bee bee hazh'ání'íí doo bááh dah na'anish. 1-800-656-8991 (TTY: 711) bich'í' hodíílnih, t'ée' 8 a.m. jí doo bik'i dah 8 p.m. jí, naakits'áadah yilt'áá' 7 bee dah naalnish.

Chinese Simplified: 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。请致电 1-800-656-8991 (TTY: 711), 服务时间为每周 7 天上午 8 点至晚上 8 点。

Chinese Traditional: 如果您說[中文], 我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務, 以無障礙格式提供資訊。請致電 1-800-656-8991 (TTY: 711), 服務時間為每週 7 天上午 8 點至晚上 8 點。

Tagalog: 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 1-800-656-8991 (TTY: 711), mula 8 a.m. hanggang 8 p.m., 7 araw sa isang linggo.

French: 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 1-800-656-8991 (TTY : 711), de 8 h à 20 h, 7 jours sur 7.

Vietnamese: 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 1-800-656-8991 (TTY: 711), từ 8 giờ sáng đến 8 giờ tối, 7 ngày trong tuần.

German: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzen zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-656-8991 (TTY: 711) an, von 8:00 bis 20:00 Uhr, 7 Tage die Woche.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services



Health
Choice

Korean: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 주 7일, 오전 8시부터 오후 8시까지 1-800-656-8991 (TTY: 711)로 전화해 주십시오.

Russian: 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. Звоните по номеру 1-800-656-8991 (линия TTY: 711), ежедневно, с 8:00 до 20:00.

Arabic

العربية

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 بالرقم 1-800-656-8991 (الهاتف النصي 711 TTY)، من الساعة 8:00 صباحًا حتى 8:00 مساءً، 7 أيام في الأسبوع.

Hindi: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-800-656-8991 (TTY: 711) पर कॉल करें, सुबह 8 बजे से रात 8 बजे तक, हफ्ते के सातों दिन।

Italian: 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 il numero 1-800-656-8991 (TTY: 711), dalle 8:00 alle 20:00, 7 giorni su 7.

Brazilian Portuguese: Se você fala português brasileiro, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-656-8991 (TTY: 711), das 8h às 20h, 7 dias por semana.

Creole (Capo Verdean): Caso fale Kabuverdianu, existem serviços de assistência linguística gratuitos disponíveis. Estão também disponíveis apoios e serviços auxiliares adequados para prestar informações em formatos acessíveis. Txoma pa 1-800-656-8991 (TTY: 711), di 8 óras di manhan ti 8 óras di noti, 7 dia pa simana.

Polish: 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 1-800-656-8991 (TTY: 711), od 8:00 do 20:00, 7 dni w tygodniu.

Japanese: 日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル(誰もが利用できるよう配慮された)な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-800-656-8991 (TTY: 711)までお問い合わせください。受付時間は週7日、午前8時から午後8時までです。

Questions about our benefits?

Call Member Services:

1-800-656-8991, TTY: 711

8 a.m. – 8 p.m., 7 days a week

HCHComments@azblue.com

Visit our website at:

azblue.com/hcpathway



**BlueCross
BlueShield**
Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

**Health
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