

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage for: Individual and/or Family | **Plan Type:** PPO



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE:** Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.floridablue.com/plancontracts/group. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.\[insert\].com](http://www.[insert].com) or call 1-800-664-5295 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	In-Network: \$1,000 Per Person/ \$2,000 Family. Out-of-Network: \$1,000 Per Person/ \$2,000 Family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	In-Network: \$6,500 Per Person/ \$13,000 Family. Out-Of-Network: \$9,000 Per Person/ \$18,000 Family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premium</u> , <u>balance-billed</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-664-5295 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	Value Choice Provider: \$30 <u>Copay</u> per Visit/ Primary Care Visits: \$30 <u>Copay</u> per Visit/ Virtual Visits: \$30 <u>Copay</u> per Visit	<u>Deductible</u> + 50% <u>Coinsurance</u> / Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are <u>only</u> covered for In-Network providers.
	<u>Specialist</u> visit	Value Choice Specialist: \$40 <u>Copay</u> per Visit/ Specialist: \$40 <u>Copay</u> per Visit/ Virtual Visits: \$40 <u>Copay</u> per Visit	<u>Deductible</u> + 50% <u>Coinsurance</u> / Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are <u>only</u> covered for In-Network providers.
	<u>Preventive care/screening/immunization</u>	No Charge, <u>Deductible</u> does not apply	50% <u>Coinsurance</u>	Physician administered drugs may have higher cost share. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Value Choice Specialist: \$40 <u>Copay</u> per Visit/ Independent Clinical Lab: No Charge, <u>Deductible</u> does not apply/ Independent Diagnostic Testing Center: \$35 <u>Copay</u> per Visit	<u>Deductible</u> + 50% <u>Coinsurance</u>	Tests performed in hospitals may have higher cost share.
	Imaging (CT/PET scans, MRIs)	\$300 <u>Copay</u> per Visit	<u>Deductible</u> + 50% <u>Coinsurance</u>	Prior Authorization may be required. Your benefits/services may be denied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.floridablue.com/members/tools-resources/pharmacy/medication-guide	Generic drugs	\$10 <u>Copay</u> per Prescription at retail, \$20 <u>Copay</u> per Prescription by home delivery	Not Covered	Up to 30 day supply for retail, 90 day supply for home delivery. Responsible Rx programs such as Prior Authorization may apply. See Medication Guide for more information.
	Preferred brand drugs	\$60 <u>Copay</u> per Prescription at retail, \$120 <u>Copay</u> per Prescription by home delivery	Not Covered	Up to 30 day supply for retail, 90 day supply for home delivery.
	Non-preferred brand drugs	\$100 <u>Copay</u> per Prescription at retail, \$200 <u>Copay</u> per Prescription by home delivery	Not Covered	Up to 30 day supply for retail, 90 day supply for home delivery.
	<u>Specialty drugs</u>	<u>Specialty drugs</u> are subject to the cost share based on applicable drug tier.	Not Covered	Up to 30 day supply for retail. Not covered through home delivery.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	<u>Deductible</u> + 30% <u>Coinsurance</u>	<u>Deductible</u> + 50% <u>Coinsurance</u>	————none————
	Physician/surgeon fees	Ambulatory Surgical Center: \$40 <u>Copay</u> per Visit/ Hospital: <u>Deductible</u> + 30% <u>Coinsurance</u>	Ambulatory Surgical Center: <u>Deductible</u> + 50% <u>Coinsurance</u> / Hospital: <u>In-Network Deductible</u> + 30% <u>Coinsurance</u>	————none————
If you need immediate medical attention	<u>Emergency room care</u>	Physician Services: 30% <u>Coinsurance</u> / Facility: \$300 <u>Copay</u> per Visit + 30% <u>Coinsurance</u>	Physician Services: 30% <u>Coinsurance</u> /Facility: \$300 <u>Copay</u> per Visit + 30% <u>Coinsurance</u>	————none————
	<u>Emergency medical transportation</u>	\$200 <u>Copay</u> per Visit	\$200 <u>Copay</u> per Visit	————none————
	<u>Urgent care</u>	\$35 <u>Copay</u> per Visit	<u>Deductible</u> + \$35 <u>Copay</u> per Visit	————none————
If you have a hospital stay	Facility fee (e.g., hospital room)	<u>Deductible</u> + 30% <u>Coinsurance</u>	<u>Deductible</u> + 50% <u>Coinsurance</u>	Inpatient Rehab Services limited to 30 days.

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	<u>Deductible</u> + 30% <u>Coinsurance</u>	<u>In-Network Deductible</u> + 30% <u>Coinsurance</u>	—————none—————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Physician Office: \$40 <u>Copay</u> per Visit / Hospital: \$30 <u>Copay</u> per Visit/ Specialist Virtual Visits: \$40 <u>Copay</u> per Visit	<u>Deductible</u> + 50% <u>Coinsurance</u> / Specialist Virtual Visits: Not Covered	Virtual Visit services are <u>only</u> covered for In-Network providers.
	Inpatient services	<u>Physician Services</u> : 30% <u>Coinsurance</u> / Hospital: <u>Deductible</u> + 30% <u>Coinsurance</u>	<u>Physician Services</u> : 30% <u>Coinsurance</u> / Hospital: <u>Deductible</u> + 50% <u>Coinsurance</u>	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	\$40 <u>Copay</u> on initial Visit	<u>Deductible</u> + 50% <u>Coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	<u>Deductible</u> + 30% <u>Coinsurance</u>	<u>In-Network Deductible</u> + 30% <u>Coinsurance</u>	—————none—————
	Childbirth/delivery facility services	Per Admission <u>Deductible</u> + <u>Deductible</u> + 30% <u>Coinsurance</u>	Per Admission <u>Deductible</u> + <u>Deductible</u> + 50% <u>Coinsurance</u>	—————none—————
If you need help recovering or have other special health needs	<u>Home health care</u>	\$20 <u>Copay</u> per Visit	<u>Deductible</u> + 50% <u>Coinsurance</u>	Unlimited visits.
	<u>Rehabilitation services</u>	\$65 <u>Copay</u> per Visit	<u>Deductible</u> + 50% <u>Coinsurance</u>	Coverage limited to 60 visits, including 20 manipulations. Services performed in hospital may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	<u>Habilitation services</u>	Not Covered	Not Covered	Not Covered
	<u>Skilled nursing care</u>	<u>Deductible</u> + 30% <u>Coinsurance</u>	<u>Deductible</u> + 50% <u>Coinsurance</u>	Unlimited days.
	<u>Durable medical equipment</u>	Motorized Wheelchairs: \$500 <u>Copay</u> / All Other: \$45 <u>Copay</u> per Visit	<u>Deductible</u> + 50% <u>Coinsurance</u>	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of <u>DME</u> due to use/age.
	<u>Hospice services</u>	\$20 <u>Copay</u> per Visit	<u>Deductible</u> + 50% <u>Coinsurance</u>	—————none—————
	Children's eye exam	Covered	Not Covered	Not Covered

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)			
- Acupuncture - Cosmetic surgery - Dental care (Adult) <u>Habilitation services</u>	- Hearing aids - Infertility treatment - Long-term care - Pediatric dental check-up - Routine eye care (Adult)	- Pediatric glasses - Private-duty nursing - Routine foot care unless for treatment of diabetes - Weight loss programs	
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)			
- Chiropractic care - Bariatric surgery	- Most coverage provided outside the United States. See www.floridablue.com. - Pediatric eye exam	- Non-emergency care when traveling outside the U.S. - Adult eye exam	

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/agencies/ebsa or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the insurer at 1-800-664-5295. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For group health coverage subject to ERISA contact your employee services department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall <u>deductible</u>	\$1,000
■ <u>Specialist Copayment</u>	\$40
■ Hospital (facility) <u>Coinsurance</u>	30%
■ Other <u>No Charge</u>	\$0

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$50
<u>Coinsurance</u>	\$2,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,310

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall <u>deductible</u>	\$1,000
■ <u>Specialist Copayment</u>	\$40
■ Hospital (facility) <u>Coinsurance</u>	30%
■ Other <u>Copayment</u>	\$45

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,900
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,900

Mia's Simple Fracture

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

■ The plan's overall <u>deductible</u>	\$1,000
■ <u>Specialist Copayment</u>	\$40
■ Hospital (facility) <u>Coinsurance</u>	30%
■ Other <u>Copayment</u>	\$300

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$700
<u>Copayments</u>	\$800
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,500

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.floridablue.com.

Section 1557 Notification: Discrimination is Against the Law

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, sex, age, or disability. We do not exclude people or treat them differently because of race, color, national origin, sex, age, or disability.

We provide:

- Free auxiliary aids, reasonable modifications, and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (e.g., large print, audio, and accessible electronic formats)
- Free language assistance 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 and vision coverage: 1-800-352-2583
- Dental, life, and disability coverage: 1-888-223-4892
- Federal Employee Program (FEP): 1-800-333-2227
- Postal Employee Program (PEP): 1-844-960-2583
- Medicare: 1-800-926-6565
- TTY 711

If you believe that we have failed to provide these services or have discriminated in another way on the basis of race, color, national origin, sex, age, or disability, you can file a grievance with:

Health and vision coverage (including FEP and PEP Members)

Section 1557 Coordinator
4800 Deerwood Campus Parkway, DCC 1-7
Jacksonville, FL 32246
1-800-477-3736 x29070
1-800-955-8770 (TTY)
Fax: 1-904-301-1580
Section1557Coordinator@bcbsfl.com

Dental, life, and disability coverage:

Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
1-800-260-0331
1-800-955-8770 (TTY)
civilrightscordinator@fclife.com

87768 0825R

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator or 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 www.hhs.gov/ocr/office/file/index.html

Visit www.floridablue.com/disclaimer/ndnotice to view an electronic version of this notice.

Se encuentran a su disposición los servicios gratuitos de idiomas, de ayuda auxiliar y de formato alternativo. Llame al número 1-800-352-2583, a FEP al 1-800-333-2227, a PEP al 1-844-960-2583, a Medicare al 1-800-926-6565, (TTY 711).

Có sẵn dịch vụ hỗ trợ ngôn ngữ miễn phí, thiết bị hỗ trợ và các định dạng thay thế. Vui lòng gọi 1-800-352-2583, FEP 1-800-333-2227, PEP 1-844-960-2583, Medicare 1-800-926-6565, (TTY 711).

Gen èd oksilyè pou ede w nan lòt lang ak sèvis nan lòt fòm ki disponib gratis. Rele nan 1-800-352-2583, FEP 1-800-333-2227, PEP 1-844-960-2583, oswa rele Medicare nan 1-800-926-6565 (TTY 711).

Estão disponíveis, gratuitamente, serviços de tradução, assistência e formatos alternativos. Ligue para 1-800-352-2583, FEP 1-800-333-2227, PEP 1-844-960-2583, Medicare 1-800-926-6565 (TTY 711).

免费语言服务、辅助援助及替代格式服务均已开放。欢迎致电以下号码 普通咨询1-800-352-2583 联邦雇员计划 (FEP) 1-800-333-2227 医疗保险 (Medicare) 1-800-926-6565 听障专线 (TTY) 711。联邦雇员计划 (FEP) 1-800-333-2227

Des services linguistiques, d'aide auxiliaire et de supports alternatifs vous sont proposés gratuitement. Appelez le 1-800-352-2583, le FEP au 1-800-333-2227, le PEP au 1-844-960-2583, le Medicare au 1-800-926-6565 (ATS 711).

May makukuhang mga libreng serbisyo sa wika, karagdagang tulong at mga alternatibong anyo. Tumawag sa 1-800-352-2583, FEP 1-800-333-2227, PEP 1-844-960-2583, Medicare 1-800-926-6565, (TTY 711).

Предоставляются бесплатные языковые услуги, вспомогательные материалы и услуги в альтернативных форматах. Звоните 1-800-352-2583, FEP 1-800-333-2227, PEP 1-844-960-2583, Medicare 1-800-926-6565 (номер для текст-телефонных устройств (TTY) 711).

الخدمات المجانية للغة، والمساعدة الإضافية، وتنسيقات بديلة متاحة. يرجى الاتصال على:
لذوي الإعاقة Medicare: 1-800-926-6565 برنامج PEP: 1-844-960-2583 برنامج FEP: 1-800-333-2227 برنامج TTY: 711 السمعية

Sono disponibili servizi gratuiti di supporto linguistico, assistenza ausiliaria e formati alternativi. Telefono: 1-800-352-2583, FEP: 1-800-333-2227, PEP: 1-844-960-2583, Medicare: 1-800-926-6565, (TTY 711).

Kostenloser Service für Sprachen, Hilfsmittel und alternative Formate verfügbar. Telefon 1-800-352-2583, FEP 1-800-333-2227, PEP 1-844-960-2583, Medicare 1-800-926-6565 (TTY 711).

무료 언어, 보조 기구 및 대체 형식 서비스를 이용할 수 있습니다. 전화 1-800-352-2583, FEP 1-800-333-2227, PEP 1-844-960-2583, 메디케어 1-800-926-6565, (TTY 711).

Bezpłatna pomoc językowa, pomoc dodatkowa oraz usługi różnego rodzaju są dostępne. Zadzwoń pod numer 1-800-352-2583, FEP 1-800-333-2227, PEP 1-844-960-2583, Medicare 1-800-926-6565, (TTY 711).

મફત ભાષા, સહાયક મદદ અને વૈકલ્પિક ફોર્મેટ સેવાઓ ઉપલબ્ધ છે.

1-800-352-2583, FEP 1-800-333-2227, PEP 1-844-960-2583, Medicare 1-800-926-6565, (TTY 711) ્ર કોલ કરો.

มีบริการภาษา ความช่วยเหลือเพิ่มเติม และบริการในรูปแบบอื่น ๆ ฟรี โทร 1-800-352-2583, FEP 1-800-333-2227, PEP 1-844-960-2583, Medicare 1-800-926-6565 (TTY 711)

無料の言語サービス、補助サービス、代替フォーマットサービスをご利用いただけます。1-800-352-2583、FEP 1-800-333-2227、PEP 1-844-960-2583、メディケア 1-800-926-6565 (TTY 711) までお電話ください。

با 1-800-333-FEP خدمات رایگان زبانی، کمکهای جانبی، و قالبهای جایگزین در دسترس هستند. با شماره 1-800-352-2583 تماس بگیرید. برای تماس بگیرید (TTY: 711) با 1-800-926-6565 Medicare و برای 2227

T'áá free yínilta'go saad bee áká anilyeedígíí, alk'ida'ánígíí, dóó t'áá ajilii hane' bee áká anilyeedígíí t'éiyá éí holne'. 1-800-352-2583 bich'j' náhodoonih, FEP bich'j' 1-800-333-2227 bich'j' náhodoonih, PEP bich'i' 1-844-960-2583 bich'j' náhodoonih, Medicare bich'j' 1-800-926-6565 bich'j' náhodoonih, (TTY 711).