



**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](http://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.floridablue.com/plancontracts/group](http://www.floridablue.com/plancontracts/group) or call 1-800-352-2583 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	In-Network: <b>\$1,500</b> Per Person/ <b>\$4,500</b> Family. Out-of-Network: <b>\$4,500</b> Per Person/ <b>\$13,500</b> Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
<b>Are there services covered before you meet your deductible?</b>	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	Yes. <b>\$500</b> Out-of-Network Per Admission Deductible. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
<b>What is the out-of-pocket limit for this plan?</b>	In-Network: <b>\$5,500</b> Per Person/ <b>\$11,000</b> Family. Out-Of-Network: <b>\$11,000</b> Per Person/ <b>\$22,000</b> Family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
<b>What is not included in the out-of-pocket limit?</b>	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="https://providersearch.floridablue.com/providersearch/pub/index.htm">https://providersearch.floridablue.com/providersearch/pub/index.htm</a> or call 1-800-352-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
<b>Do you need a referral to see a specialist?</b>	No.	You can see the specialist you choose without a referral.

 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)	
<b>If you visit a health care <u>provider's</u> office or clinic</b>	Primary care visit to treat an injury or illness	Value Choice Provider: No Charge, <u>Deductible</u> does not apply/ Primary Care Visits: \$30 <u>Copay</u> per Visit/ Virtual Visits: No Charge, <u>Deductible</u> does not apply	<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: \$20 <u>Copay</u> per Visit/ Specialist: \$55 <u>Copay</u> per Visit/ Virtual Visits: \$55 <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.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	Value Choice Specialist: \$20 <u>Copay</u> per Visit/ Independent Clinical Lab: No Charge, <u>Deductible</u> does not apply/ Independent Diagnostic Testing Center: \$50 <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)	\$250 <u>Copay</u> per Visit	<u>Deductible</u> + 50% <u>Coinsurance</u>	Tests performed in hospitals may have higher cost share. 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="https://www.floridablue.com/members/tools-resources/pharmacy/medication-guide">https://www.floridablue.com/members/tools-resources/pharmacy/medication-guide</a>	Generic drugs	\$10 <u>Copay</u> per Prescription at retail, \$25 <u>Copay</u> per Prescription by mail	50% <u>Coinsurance</u>	Up to 30 day supply for retail, 90 day supply for mail order. 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, \$150 <u>Copay</u> per Prescription by mail	50% <u>Coinsurance</u>	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	\$100 <u>Copay</u> per Prescription at retail, \$250 <u>Copay</u> per Prescription by mail	50% <u>Coinsurance</u>	Up to 30 day supply for retail, 90 day supply for mail order.
	Specialty drugs	20% <u>Coinsurance</u> at retail	50% <u>Coinsurance</u>	Up to 30 day supply for retail. Not covered through Mail Order.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgical Center: \$200 <u>Copay</u> per Visit/ Hospital: <u>Deductible</u> + 30% <u>Coinsurance</u>	<u>Deductible</u> + 50% <u>Coinsurance</u>	—————none—————
	Physician/surgeon fees	Ambulatory Surgical Center: \$55 <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—————
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	Physician Services: <u>Deductible</u> + 30% <u>Coinsurance</u> / Facility: \$250 <u>Copay</u> per Visit	Physician Services: <u>In-Network Deductible</u> + 30% <u>Coinsurance</u> / Facility: \$250 <u>Copay</u> per Visit	—————none—————
	<u>Emergency medical transportation</u>	<u>Deductible</u> + 30% <u>Coinsurance</u>	<u>In-Network Deductible</u> + 30% <u>Coinsurance</u>	—————none—————
	<u>Urgent care</u>	Value Choice Provider: No Charge, <u>Deductible</u> does not	<u>Deductible</u> + \$60 <u>Copay</u> per Visit	—————none—————

For more information about limitations and exceptions, see the [plan](#) or policy document at [www.floridablue.com/plancontracts/group](http://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)	
		apply - Visits 1-2;\$60 Copay per remaining Visit/ Urgent Care Visits: \$60 Copay per Visit		
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible + 30% Coinsurance	Per Admission Deductible + Deductible + 50% Coinsurance	Inpatient Rehab Services limited to 30 days.
	Physician/surgeon fees	Deductible + 30% Coinsurance	In-Network Deductible + 30% Coinsurance	—————none—————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge, Deductible does not apply	50% Coinsurance/ Specialist Virtual Visits: Not Covered	Virtual Visit services are <u>only</u> covered for In-Network providers.
	Inpatient services	No Charge, Deductible does not apply	Physician Services: No Charge, Deductible does not apply/ Hospital: 50% Coinsurance	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	\$55 Copay on initial Visit	Deductible + 50% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 30% Coinsurance	In-Network Deductible + 30% Coinsurance	—————none—————
	Childbirth/delivery facility services	Deductible + 30% Coinsurance	Per Admission Deductible + Deductible + 50% Coinsurance	—————none—————
If you need help recovering or have other special health needs	Home health care	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	Coverage limited to 60 visits.
	Rehabilitation services	\$55 Copay per Visit	Deductible + 50% Coinsurance	Coverage limited to 35 visits, including 26 manipulations. Services performed in hospital may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 30% Coinsurance	Deductible + 50%	Coverage limited to 60 days.

For more information about limitations and exceptions, see the [plan](#) or policy document at [www.floridablue.com/plancontracts/group](http://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)	
			Coinsurance	
	Durable medical equipment	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of <u>DME</u> due to use/age.
	Hospice services	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	—————none—————
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	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 <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Bariatric surgery</li> <li>Cosmetic surgery</li> <li>Dental care (Adult)</li> <li>Habilitation services</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids</li> <li>Infertility treatment</li> <li>Long-term care</li> <li>Pediatric dental check-up</li> <li>Pediatric eye exam</li> </ul>	<ul style="list-style-type: none"> <li>Pediatric glasses</li> <li>Private-duty nursing</li> <li>Routine eye care (Adult)</li> <li>Routine foot care unless for treatment of diabetes</li> <li>Weight loss programs</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> <li>Chiropractic care - Limited to 35 visits</li> </ul>	<ul style="list-style-type: none"> <li>Most coverage provided outside the United States. See <a href="http://www.floridablue.com">www.floridablue.com</a>.</li> </ul>	<ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S.</li> </ul>

**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](http://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](http://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](http://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 1-800-352-2583. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits

For more information about limitations and exceptions, see the plan or policy document at [www.floridablue.com/plancontracts/group](http://www.floridablue.com/plancontracts/group).

Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](http://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.

**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.

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

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For more information about limitations and exceptions, see the plan or policy document at [www.floridablue.com/plancontracts/group](http://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 <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist Copayment</u>	\$55
■ <u>Hospital (facility) Coinsurance</u>	30%
■ <u>Other 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$70
<u>Coinsurance</u>	\$2,100
<u>What isn't covered</u>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,730</b>

### Managing Joe's type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist Copayment</u>	\$55
■ <u>Hospital (facility) Coinsurance</u>	30%
■ <u>Other Coinsurance</u>	30%

#### 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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#### In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$2,000
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$2,000</b>

### Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist Copayment</u>	\$55
■ <u>Hospital (facility) Coinsurance</u>	30%
■ <u>Other Copayment</u>	\$250

#### This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$2,800</b>
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#### In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$600
<u>Coinsurance</u>	\$60
<u>What isn't covered</u>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,160</b>

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](http://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, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

We provide:

- 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)
- 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 and vision coverage: 1-800-352-2583
- Dental, life, and disability coverage: 1-888-223-4892
- Federal Employee Program: 1-800-333-2227

If you believe that we have failed to provide these services or discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation, you can file a grievance with:

**Health and vision coverage (including FEP 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@floridablue.com](mailto:section1557coordinator@floridablue.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)  
[civilrightscoordinator@fclife.com](mailto:civilrightscoordinator@fclife.com)

Health insurance is offered by Florida Blue. HMO coverage is offered by Florida Blue HMO, an affiliate of Florida Blue. Dental insurance is offered by Florida Combined Life Insurance Company, Inc., an affiliate of Blue Cross and Blue Shield of Florida, Inc. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.

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

**ATENCIÓN:** Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-352-2583 (TTY: 1-877-955-8773). FEP: Llame al 1-800-333-2227

**ATANSYON:** Si w pale Kreyòl ayisyen, ou ka resevwa yon èd gratis nan lang pa w. Rele 1-800-352-2583 (pou moun ki pa tande byen: 1-800-955-8770). FEP: Rele 1-800-333-2227

**CHÚ Ý:** Nếu bạn nói Tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho bạn. Hãy gọi số 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Gọi số 1-800-333-2227

**ATENÇÃO:** Se você fala português, utilize os serviços linguísticos gratuitos disponíveis. Ligue para 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Ligue para 1-800-333-2227

**注意:** 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-352-2583 (TTY: 1-800-955-8770)。FEP：請致電1-800-333-2227

**ATTENTION:** Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-352-2583 (ATS : 1-800-955-8770). FEP : Appelez le 1-800-333-2227

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Tumawag sa 1-800-333-2227

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-352-2583 (телетайп: 1-800-955-8770). FEP: Звоните 1-800-333-2227

ملحوظة: إذا كنت تتحدث انكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-352-2583 (رقم هاتف الصم والبكم: 1-800-955-8770). اتصل برقم 1-800-333-2227.

ATTENZIONE: Qualora fosse l'italiano la lingua parlata, sono disponibili dei servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-352-2583 (TTY: 1-800-955-8770). FEP: chiamare il numero 1-800-333-2227

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: +1-800-352-2583 (TTY: +1-800-955-8770). FEP: Rufnummer +1-800-333-2227

주의: 한국어 사용을 원하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-352-2583 (TTY: 1-800-955-8770) 로 전화하십시오. FEP: 1-800-333-2227 로 연락하십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Zadzwoń pod numer 1-800-333-2227.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવા તમારા માટે ઉપલબ્ધ છે.

ફોન કરો 1-800-352-2583 (TTY: 1-800-955-8770). FEP: ફોન કરો 1-800-333-2227

ประกาศ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โดยติดต่อหมายเลขโทรศัพท์ 1-800-352-2583 (TTY: 1-800-955-8770) หรือ FEP โทร 1-800-333-2227

注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。1-800-352-2583 (TTY: 1-800-955-8770) まで、お電話にてご連絡ください。FEP: 1-800-333-2227

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی رایگان در دسترس شما خواهد بود. با شماره 1-800-352-2583 (TTY: 1-800-955-8770) تماس بگیرید. FEP: با شماره 1-800-333-2227 تماس بگیرید.

Baa ákonínzin: Diné bizaad bee yáníiti'go, saad bee áká anáwo', t'áá jíik'eh, ná hóló. Kojí' hodíílnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP ígíí éí kojí' hodíílnih 1-800-333-2227.

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