



Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage for:** Individual and/or Family | **Plan Type:** PPO/EPO

 **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/individual. 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/individual or call 1-800-352-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$0 at Indian Health Care <u>Provider</u> (IHCP) or with IHCP <u>referral</u> at non-IHCP; or <u>In-Network</u> : \$5,950 Per Person/ \$11,900 Family. <u>Out-of-Network</u> : \$11,900 Per Person/ \$23,800 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 deductible?	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 deductibles for specific services?	\$0 at Indian Health Care <u>Provider</u> (IHCP) or with IHCP <u>referral</u> at non-IHCP; or Yes. \$3,000 Pharmacy <u>Deductible</u> ; . There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the out-of-pocket limit for this plan?	Yes. <u>In-Network</u> : \$7,150 Per Person/ \$14,300 Family. <u>Out-Of-Network</u> : \$14,300 Per Person/ \$28,600 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 out-of-pocket limit?	<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> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider ?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm 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.
Do you need a referral to see a specialist ?	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
		Indian Health Care Provider (You have no cost)	Non-IHCP In-Network Provider (You will pay the less)	Out-of-Network Provider (You will pay most)	
If you visit a health care <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	No Charge	Value Choice Provider: No Charge/ Primary Care Visits: \$50 Copay per Visit/ Virtual Visits: No Charge	Deductible + 50% Coinsurance / Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	<u>Specialist</u> visit	No Charge	Value Choice Specialist: \$20 Copay per Visit/ Specialist: \$100 Copay per Visit/ Virtual Visits: \$100 Copay per Visit	Deductible + 50% Coinsurance / Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	<u>Preventive care/screening/immunization</u>	No Charge	No Charge	50% Coinsurance	Physician administered drugs may have higher cost share. You may have to pay for services that aren't preventive . Ask your provider if the services needed are preventive . Then check what your plan will pay for.

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (You have no cost)	Non-IHCP In-Network Provider (You will pay the less)	Out-of-Network Provider (You will pay most)	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No Charge	Value Choice Specialist: \$20 <u>Copay</u> per Visit/ Independent Clinical Lab: \$25 <u>Copay</u> per Visit/ Independent Diagnostic Testing Center: \$175 <u>Copay</u> per Visit	Independent Clinical Lab: Not Covered/ Independent Diagnostic Testing Center: <u>Deductible</u> + 50% <u>Coinsurance</u>	Tests performed in hospitals may have higher cost share.
	Imaging (CT/PET scans, MRIs)	No Charge	\$400 <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.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.floridablue.com/tols-resources/pharmacy/medication-guide	Generic drugs	No Charge	<u>Preventive</u> : No Charge (retail)/ Condition Care Rx: \$4 <u>Copay</u> per Prescription (retail)/ All Other Generic: \$15 <u>Copay</u> per Prescription (retail)	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order at 2 1/2 times the retail amount. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information.
	Preferred brand drugs	No Charge	Condition Care Rx: \$34 <u>Copay</u> per Prescription (retail)/ All Other Preferred Brand: \$3,000 Pharmacy <u>Deductible</u> + \$67 <u>Copay</u> per Prescription (retail)	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order at 2 1/2 times the retail amount.
	Non-preferred brand drugs	No Charge	\$3,000 Pharmacy	Not Covered	Up to 30 day supply for retail, 90

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (You have no cost)	Non-IHCP In-Network Provider (You will pay the less)	Out-of-Network Provider (You will pay most)	
			Deductible + 50% Coinsurance (retail)		day supply for mail order at 2 1/2 times the retail amount.
	<u>Specialty drugs</u>	No Charge	\$3,000 Pharmacy Deductible + 50% Coinsurance	Not Covered	Up to 30 day supply for retail. Not covered through Mail Order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Ambulatory Surgical Center: Deductible + \$400 Copay per Visit/ Hospital: Deductible + \$500 Copay per Visit	Deductible + 50% Coinsurance	—————none—————
	Physician/surgeon fees	No Charge	\$100 Copay per Visit	\$100 Copay per Visit	—————none—————
If you need immediate medical attention	<u>Emergency room care</u>	No Charge	Deductible + \$350 Copay per Visit	In-Network Deductible + \$350 Copay per Visit	—————none—————
	<u>Emergency medical transportation</u>	No Charge	Deductible + 40% Coinsurance	In-Network Deductible + 40% Coinsurance	—————none—————
	<u>Urgent care</u>	No Charge	Value Choice Provider: No Charge - Visits 1-2 \$100 Copay for remaining Visits/ Urgent Care Visits: \$100 Copay per Visit	Value Choice Provider: Not Covered/ Urgent Care Visits: Deductible + \$100 Copay per Visit	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Deductible + \$600 Copay per Admission	Deductible + 50% Coinsurance	Inpatient Rehab Services limited to 30 days. Inpatient Habilitation Services limited to 30 days.
	Physician/surgeon fees	No Charge	\$100 Copay per Visit	\$100 Copay per Visit	—————none—————

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (You have no cost)	Non-IHCP In-Network Provider (You will pay the less)	Out-of-Network Provider (You will pay most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	Physician Office: \$100 <u>Copay</u> per Visit/ Specialist Virtual Visits: No Charge/ Hospital: <u>Deductible</u> + \$500 <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	No Charge	Physician Services: \$100 <u>Copay</u> per Visit / Hospital: <u>Deductible</u> + \$600 <u>Copay</u> per Admission	Physician Services: <u>In-Network Deductible</u> + 40% <u>Coinsurance</u> / Hospital: <u>Deductible</u>	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	No Charge	\$100 <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	No Charge	\$100 <u>Copay</u> per Visit	\$100 <u>Copay</u> per Visit	—————none—————
	Childbirth/delivery facility services	No Charge	<u>Deductible</u> + \$600 <u>Copay</u> per Admission	<u>Deductible</u> + 50% <u>Coinsurance</u>	—————none—————
If you need help recovering or have other special health needs	<u>Home health care</u>	No Charge	No Charge	Not Covered	Coverage limited to 60 visits.
	<u>Rehabilitation services</u>	No Charge	\$100 <u>Copay</u> per Visit	<u>Deductible</u> + 50% <u>Coinsurance</u>	Coverage limited to 35 visits, including 35 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>	No Charge	\$100 <u>Copay</u> per Visit	<u>Deductible</u> + 50% <u>Coinsurance</u>	Coverage limited to 35 visits. Services performed in hospital may have higher cost share. Prior

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (You have no cost)	Non-IHCP In-Network Provider (You will pay the less)	Out-of-Network Provider (You will pay most)	
					Authorization may be required. Your benefits/services may be denied.
	<u>Skilled nursing care</u>	No Charge	\$500 <u>Copay</u> per Visit	<u>Deductible</u> + 50% <u>Coinsurance</u>	Coverage limited to 60 days.
	<u>Durable medical equipment</u>	No Charge	Motorized Wheelchairs: \$500 <u>Copay</u> per Visit/ All Other: No Charge	Not Covered	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of <u>DME</u> due to use/age.
	<u>Hospice services</u>	No Charge	No Charge	<u>Deductible</u> + 50% <u>Coinsurance</u>	—————none—————
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	Not Covered	One exam every 12 months.
	Children's glasses	No Charge	No Charge	Not Covered	One pair every 12 months. Additional cost shares may apply for Non-Collection Frame.
	Children's dental check-up	Not Covered	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"> • Acupuncture • Bariatric surgery • Cosmetic surgery • Dental care (Adult) • Hearing aids 	<ul style="list-style-type: none"> • Infertility treatment • Long-term care • Non-accepted abortions (i.e., not <u>medically necessary</u>) • Pediatric dental check-up 	<ul style="list-style-type: none"> • Private-duty nursing • Routine eye care (Adult) • 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 <u>plan</u> document.)		
<ul style="list-style-type: none"> • Chiropractic care - Limited to 35 visits 	<ul style="list-style-type: none"> • Most coverage provided outside the United States. See www.floridablue.com. 	<ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S.

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or

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

www.dol.gov/ebsa/contactEBSA/consumerassistance.html, State consumer assistance program www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/, Office of Personnel Management Multi State Plan Program: www.opm.gov/healthcare-insurance/multi-state-plan-program/externalreview/. Or Healthcare.gov www.HealthCare.gov or call 1-800-318-2596 OR state [health insurance marketplace](#) or SHOP. 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 1-800-352-2583. You may also contact your State Department of Insurance 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/consumer_info_health.html.

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? Not Applicable

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/individual.

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 deductible** \$5,950
- **Specialist Copayment** \$100
- **Hospital (facility) Copayment** \$600
- **Other Copayment** \$25

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

In this example, Peg would pay:

<u>Cost Sharing</u>	
Deductibles	\$5,950
Copayments	\$900
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$6,910

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** \$5,950
- **Specialist Copayment** \$100
- **Hospital (facility) Copayment** \$600
- **Other No Charge** \$0

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

In this example, Joe would pay:

<u>Cost Sharing</u>	
Deductibles*	\$3,000
Copayments	\$1,300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$30
The total Joe would pay is	\$4,330

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** \$5,950
- **Specialist Copayment** \$100
- **Hospital (facility) Copayment** \$600
- **Other Copayment** \$350

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

In this example, Mia would pay:

<u>Cost Sharing</u>	
Deductibles	\$1,200
Copayments	\$600
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,800

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.

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.

Section 1557 Notification: Discrimination is Against the Law

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO (collectively, "Florida Blue"), Florida Combined Life and the Blue Cross and Blue Shield Federal Employee Program® (FEP) 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.

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO, Florida Combined Life and FEP:

- 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)
- Provide 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:

- Florida Blue (health and vision coverage): 1-800-352-2583
- Florida Combined Life (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 discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Florida Blue (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

Florida Combined Life:

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

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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

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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 اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-352-2583 (رقم هاتف الصم والبكم: 1-800-955-8770). اتصل برقم 1-333-008-1.
.7222

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.

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

ફોન ક્રમે [1-800-352-2583](tel:1-800-352-2583) (TTY: [1-800-955-8770](tel:1-800-955-8770)). FEP: **ફોન ક્રમે** [1-800-333-2227](tel: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 yániití'go, saad bee áká anáwo', t'áá jíik'eh, ná hóló. Kojj' hodiílnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP **ígíí éi kojj' hodiílnih 1-800-333-2227.**

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