

 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, visit www.hmsa.com.

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 <http://www.healthcare.gov/sbc-glossary/> or call 1-800-776-4672 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | For network providers \$0 For out-of-network providers \$100 individual / \$300 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 . |
| Are there services covered before you meet your deductible? | Yes. All services received from a participating or in-network provider will be covered before you meet your deductible . | 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | No. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan? | \$2,500 individual / \$7,500 family (applies to medical plan coverage). \$3,600 individual / \$4,200 family (applies to prescription drug coverage). | 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. |
| What is not included in the out-of-pocket limit? | Premiums , balance-billed charges , payments for services subject to a maximum once you reach the maximum, any amounts you owe in addition to your copayment for covered services, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit . |
| Will you pay less if you use a network provider? | Yes. See http://www.hmsa.com/search/providers or call 1-800-776-4672 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 |
|--|--|--|---|--|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$12 copay /visit | 30% coinsurance | ---none--- |
| | Specialist visit | \$12 copay /visit | 30% coinsurance | ---none--- |
| | Other practitioner office visit: | | | |
| | Physical and Occupational Therapist | 20% coinsurance | 30% coinsurance | Services may require preauthorization . Benefits may be denied if preauthorization is not obtained. |
| | Psychologist | \$12 copay /visit | 30% coinsurance | ---none--- |
| | Nurse Practitioner | \$12 copay /visit | 30% coinsurance | ---none--- |
| | Preventive care (Well Child Physician Visit) | No charge | 30% coinsurance ; deductible does not apply | Age and frequency limitations may apply. 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. |
| | Screening | No charge | 30% coinsurance | |
| | Immunization (Standard and Travel) | No charge | 30% coinsurance | |
| If you have a test | Diagnostic test | | | |
| | Inpatient | 10% coinsurance | 30% coinsurance | Services may require preauthorization . Benefits may be denied if preauthorization is not obtained. |
| | Outpatient | 20% coinsurance | 30% coinsurance | |
| | X-ray | | | |
| | Inpatient | 10% coinsurance | 30% coinsurance | Services may require preauthorization . Benefits may be denied if preauthorization is not obtained. |
| | Outpatient | 20% coinsurance | 30% coinsurance | |
| | Blood Work | | | |
| | Inpatient | 10% coinsurance | 30% coinsurance | Services may require preauthorization . Benefits may be denied if preauthorization is not obtained. |
| | Outpatient | 20% coinsurance | 30% coinsurance | |

| 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 have a test | Imaging (CT/PET scans, MRIs) | | | |
| | Inpatient | 10% coinsurance | 30% coinsurance | Services may require preauthorization . Benefits may be denied if preauthorization is not obtained. |
| | Outpatient | 20% coinsurance | 30% coinsurance | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.hmsa.com . | Tier 1 – mostly Generic drugs (retail) | \$7 copay /prescription | \$7 copay and 20% coinsurance /prescription; deductible does not apply | One retail copay for 1-30 day supply, two retail copays for 31-60 day supply, and three retail copays for 61-90 day supply. |
| | Tier 1 – mostly Generic drugs (mail order) | \$11 copay /prescription | Not covered | One mail order copay for a 84-90 day supply at a 90 day at retail network or contracted mail order provider. |
| | Tier 2 – mostly Preferred Formulary Drugs (retail) | \$30 copay /prescription | \$30 copay and 20% coinsurance /prescription; deductible does not apply | One retail copay for 1-30 day supply, two retail copays for 31-60 day supply, and three retail copays for 61-90 day supply. |
| | Tier 2 – mostly Preferred Formulary Drugs (mail order) | \$65 copay /prescription | Not covered | One mail order copay for a 84-90 day supply at a 90 day at retail network or contracted mail order provider. |
| | Tier 3 – mostly Non-preferred Formulary Drugs (retail) | \$30 copay /prescription | \$30 copay and 20% coinsurance /prescription; deductible does not apply | In addition to your copay and/or coinsurance , you will be responsible for a \$45 Tier 3 Cost Share per retail copay . Cost to you for retail Tier 3 drugs: One copay plus one Tier 3 Cost Share for 1-30 day supply, two copays plus two Tier 3 Cost Shares for 31-60 day supply, and three copays plus three Tier 3 Cost Shares for 61-90 day supply. |

| 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 need drugs to treat your illness or condition More information about prescription drug coverage is available at www.hmsa.com . | Tier 3 – mostly Non-preferred Formulary Drugs (mail order) | \$65 copay /prescription | Not covered | In addition to your copay and/or coinsurance , you will be responsible for a \$135 Tier 3 Cost Share per mail order copay . Cost to you for mail order Tier 3 drugs: One mail order copay plus one mail order Tier 3 Cost Share for an 84-90 day supply at a 90 day at retail network or contracted mail order provider. |
| | Tier 4 – mostly Preferred Formulary Specialty drugs (retail) | \$100 copay /prescription | Not covered | Retail benefits for Tier 4 and Tier 5 drugs are limited to a 30-day supply. Available in participating Specialty Pharmacies only. |
| | Tier 5 – mostly Non-preferred Formulary Specialty drugs (retail) | \$200 copay /prescription | Not covered | |
| | Tier 4 & 5 (mail order) | Not covered | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 30% coinsurance | ---none--- |
| | Physician Visits | \$12 copay /visit | 30% coinsurance | ---none--- |
| | Surgeon fees | 10% coinsurance (cutting) | 30% coinsurance (cutting) | ---none--- |
| | | 20% coinsurance (non-cutting) | 30% coinsurance (non-cutting) | ---none--- |
| If you need immediate medical attention | Emergency room care | | | |
| | Physician Visit | \$12 copay /visit | \$12 copay /visit; deductible does not apply | ---none--- |
| | Emergency room | 20% coinsurance | 20% coinsurance ; deductible does not apply | ---none--- |
| | Emergency medical transportation (air) | 20% coinsurance | 30% coinsurance | Limited to air transport to the nearest adequate hospital within the State of Hawaii, except in certain situations when transportation to the continental US is necessary for critical care in accord with HMSA's medical policy. Certain exclusions apply. |

| 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 need immediate medical attention | Emergency medical transportation (ground) | 20% coinsurance | 30% coinsurance | Ground transportation to the nearest, adequate hospital to treat your illness or injury. |
| | Urgent care | \$12 copay /visit | 30% coinsurance | ---none--- |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 10% coinsurance | 30% coinsurance | ---none--- |
| | Physician Visits | \$12 copay /visit | 30% coinsurance | ---none--- |
| | Surgeon fee | 10% coinsurance (cutting) | 30% coinsurance (cutting) | ---none--- |
| | | 20% coinsurance (non-cutting) | 30% coinsurance (non-cutting) | ---none--- |
| If you have mental health, behavioral health, or substance abuse needs | Outpatient services | | | |
| | Physician services | \$12 copay /visit | 30% coinsurance | ---none--- |
| | Hospital and facility services | 10% coinsurance | 30% coinsurance | ---none--- |
| | Inpatient services | | | |
| | Physician services | 10% coinsurance | 30% coinsurance | ---none--- |
| | Hospital and facility services | 10% coinsurance | 30% coinsurance | ---none--- |
| If you are pregnant | Office visit (Prenatal and postnatal care) | 10% coinsurance | 30% coinsurance | Cost sharing does not apply to certain preventive services . Depending on the type of services, coinsurance or copay may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 10% coinsurance | 30% coinsurance | |
| | Childbirth/delivery facility services | 10% coinsurance | 30% coinsurance | |
| If you need help recovering or have other special health needs | Home health care | No charge | 30% coinsurance | 150 Visits per Calendar Year |
| | Rehabilitation services | 20% coinsurance | 30% coinsurance | Services may require preauthorization . Benefits may be denied if preauthorization is not obtained. Excludes cardiac rehabilitation. |
| | Habilitation services | Not covered | Not covered | Excluded service |
| | Skilled nursing care | 10% coinsurance | 30% coinsurance | 120 Days per Calendar Year. Includes extended care facilities (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities) to the extent care is for Skilled nursing care , sub-acute care, or long-term acute care. |

| 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 need help recovering or have other special health needs | Durable medical equipment | 20% coinsurance | 30% coinsurance | Services may require preauthorization . Benefits may be denied if preauthorization is not obtained. |
| | Hospice services | No charge | Not covered | ---none--- |
| If your child needs dental or eye care | Children's eye exam | \$10 copay /exam | 50% coinsurance ; deductible does not apply | Limited to one routine vision exam per calendar year. |
| | Children's glasses (single vision lenses and frames selected within designated group) | \$25 copay /glasses | 50% coinsurance ; deductible does not apply | The frequency in which you can obtain a pair of glasses may vary |
| | Children's dental check-up | Not covered | Not covered | Excluded service |

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 .) | | |
|---|--|---|
| <ul style="list-style-type: none"> Acupuncture Cardiac rehabilitation Cosmetic surgery Dental care (Adult) | <ul style="list-style-type: none"> Dental care (Child) Habilitation services Long-term care Private-duty nursing | <ul style="list-style-type: none"> Routine foot care Weight loss programs |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|--|--|--|
| <ul style="list-style-type: none"> Bariatric surgery Chiropractic care (e.g., office visits, x-ray films – limited to services covered by this medical plan and within the scope of a chiropractor's license) Hearing aids (limited to one hearing aid per ear every 60 months) | <ul style="list-style-type: none"> Infertility Treatment (Artificial Insemination and In Vitro Fertilization. Please refer to your plan document for limitations and additional details) Non-emergency care when traveling outside the U.S. For more information, see www.hmsa.com | <ul style="list-style-type: none"> Routine eye care (Adult) (limited to services covered under a rider) |

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: 1) 1-800-776-4672 for HMSA; 2) (808) 586-2790 for the State of Hawaii, Dept. of Commerce and Consumer Affairs – Insurance Division; 3) 1-866-444-3272 or <http://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act> for the U.S. Department of Labor, Employee Benefits Security Administration; or 4) 1-877-267-2323 x61565 or <http://www.cciio.cms.gov> for the U.S. Department of Health and Human Services. Church plans are not covered by the Federal COBRA continuation coverage rules. 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 <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:

- For group health coverage subject to ERISA, you must submit a written request for an [appeal](#) to: HMSA Member Advocacy and Appeals, P.O. Box 1958, Honolulu, Hawaii 96805-1958. If you have any questions about [appeals](#), you can call us at (808) 948-5090 or toll free at 1-800-462-2085. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act>. You may also file a [grievance](#) with the Insurance Commissioner. You must send the request to the Insurance Commissioner at: Hawaii Insurance Division, ATTN: Health Insurance Branch – External Appeals, 335 Merchant Street, Room 213, Honolulu, Hawaii 96813. Telephone: (808) 586-2804.
- For non-federal governmental group health plans and church plans that are group health plans, you must submit a written request for an [appeal](#) to: HMSA Member Advocacy and Appeals, P.O. Box 1958, Honolulu, Hawaii 96805-1958. If you have any questions about [appeals](#), you can call us at (808) 948-5090 or toll free at 1-800-462-2085. You may also file a [grievance](#) with the Insurance Commissioner. You must send the request to the Insurance Commissioner at: Hawaii Insurance Division, ATTN: Health Insurance Branch – External Appeals, 335 Merchant Street, Room 213, Honolulu, Hawaii 96813. Telephone: (808) 586-2804.

Does this Coverage 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 Coverage Meet the Minimum Value Standard? 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](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-776-4672.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-776-4672.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-776-4672.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-776-4672.

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

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 | \$0 |
| ■ Specialist copayment | \$12 |
| ■ Hospital (facility) coinsurance | 10% |
| ■ Other coinsurance | 20% |

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: | |
| <i>Cost Sharing</i> | |
| Deductibles | \$0 |
| Copayments | \$20 |
| Coinsurance | \$1,300 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$1,380 |

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

| | |
|---|------|
| ■ The plan's overall deductible | \$0 |
| ■ Specialist copayment | \$12 |
| ■ Hospital (facility) coinsurance | 10% |
| ■ Other coinsurance | 20% |

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: | |
| <i>Cost Sharing</i> | |
| Deductibles | \$0 |
| Copayments | \$300 |
| Coinsurance | \$200 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$520 |

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

| | |
|---|------|
| ■ The plan's overall deductible | \$0 |
| ■ Specialist copayment | \$12 |
| ■ Hospital (facility) coinsurance | 10% |
| ■ Other coinsurance | 20% |

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: | |
| <i>Cost Sharing</i> | |
| Deductibles | \$0 |
| Copayments | \$70 |
| Coinsurance | \$400 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$470 |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Federal law requires HMSA to provide you with this notice.

HMSA complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. HMSA does not exclude people or treat them differently because of things like race, color, national origin, age, disability, or sex.

Services that HMSA provides

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

- Qualified interpreters
- Information written in other languages
- If you need these services, please call 1 (800) 776-4672 toll-free; TTY 711

How to file a discrimination-related grievance or complaint

If you believe that we've failed to provide these services or discriminated against you in some way, you can file a grievance in any of the following ways:

- Phone: 1 (800) 776-4672 toll-free
- TTY: 711
- Email: Compliance_Ethics@hmsa.com
- Fax: (808) 948-6414 on Oahu
- Mail: 818 Keeaumoku St., Honolulu, HI 96814

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, in any of the following ways:

- Online: ocrportal.hhs.gov/ocr/portal/lobby.jsf
- Phone: 1 (800) 368-1019 toll-free; TDD users, call 1 (800) 537-7697 toll-free

- Mail: U.S. Department of Health and Human Services, 200 Independence Ave. S.W., Room 509F, HHH Building, Washington, DC 20201

For complaint forms, please go to hhs.gov/ocr/office/file/index.html.

Hawaiian: E NĀNĀ MAI: Inā ho'opuka 'oe i ka 'Ōlelo Hawai'i, loa'a ke kōkua manuahi iā 'oe. E kelepona iā 1 (800) 776-4672. TTY 711.

Bisaya: ATENSYON: Kung nagsulti ka og Cebuano, aduna kay magamit nga mga serbisyo sa tabang sa lengguwahe, nga walay bayad. Tawag sa 1 (800) 776-4672 nga walay toll. TTY 711.

Chinese: 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) 776-4672。TTY 711.

Ilocano: PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 1 (800) 776-4672 toll-free. TTY 711.

Japanese: 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) 776-4672 をご利用ください。TTY 711. まで、お電話にてご連絡ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1 (800) 776-4672번으로 연락해 주시기 바랍니다. TTY 711 번으로 전화해 주십시오.

Laotian: ກະລຸນາສັງເກດ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການຊ່ວຍເຫຼືອດ້ານພາສາ, ບໍ່ມີຄ່າໃຊ້ຈ່າຍ, ແມ່ນມີໃຫ້ທ່ານ. ໂທ 1 (800) 776-4672 ພຣີ. TTY 711.

Marshallese: LALE: Ñe kwōj kōnono Kajin Majōl, kwomaroñ bōk jermal in jipañ ilo kajin ñe am ejjelōk

wōñāñ. Kaalōk 1 (800) 776-4672 tollfree, enaj ejjelok wonaan. TTY 711.

Pohnpeian: Ma ke kin lokaian Pohnpei, ke kak ale sawas in sohte pweine. Kahlda nempe wet 1 (800) 776-4672. Me sohte kak rong call TTY 711.

Samoan: MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se todogi, mo oe, Telefoni mai: 1 (800) 776-4672 e leai se todogi o lenei 'au'aunaga. TTY 711.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1 (800) 776-4672. TTY 711.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1 (800) 776-4672 toll-free. TTY 711.

Tongan: FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea teke lava 'o ma'u ia. Telefoni mai 1 (800) 776-4672. TTY 711.

Trukese: MEI AUCHEA: Ika iei foosun fonuomw: Foosun Chuuk, iwe en mei tongeni omw kopwe angei aninisin chiakku, ese kamo. Kori 1 (800) 776-4672, ese kamo. TTY 711.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1 (800) 776-4672. TTY 711.



An Independent Licensee of the Blue Cross and Blue Shield Association

NMM_1000_24715_1557_R