



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](http://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 [www.healthcare.gov/sbc-glossary](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 <a href="#">deductible</a> ?	\$0	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Not applicable.	This <a href="#">plan</a> does not have a <a href="#">deductible</a> . You do not have to meet a <a href="#">deductible</a> amount before the <a href="#">plan</a> pays for any services.
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Medical: <b>\$2,500</b> individual / <b>\$5,000</b> family. Drug: <b>\$4,350</b> individual / <b>\$8,700</b> family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billed charges</a> , payments for services subject to a maximum once you reach the maximum, any amounts you owe in addition to your <a href="#">copayment</a> for covered services, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.hmsa.com/search/providers">www.hmsa.com/search/providers</a> or call 1-800-776-4672 for a list of <a href="#">network providers</a> . For a list of in-network retail pharmacies, see <a href="http://www.caremark.com">www.caremark.com</a> or call 1-855-801-8263.	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 <a href="#">provider's office</a> or clinic	Primary care visit to treat an injury or illness	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	---none---
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	---none---
	<a href="#">Preventive care</a> (Well Child physician visit)	No charge	No charge	Age and frequency limitations may apply. You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
	<a href="#">Screening</a>	No charge	No charge	
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a> No charge for outpatient blood work	20% <a href="#">coinsurance</a> No charge for outpatient blood work	Services may require <a href="#">preauthorization</a> . Benefits may be denied if <a href="#">preauthorization</a> is not obtained.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Services may require <a href="#">preauthorization</a> . Benefits may be denied if <a href="#">preauthorization</a> is not obtained.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a>	Generic drugs (30/60/90-day supply)	<b>Retail/Mail:</b> \$5/\$9/\$9 <a href="#">copayment</a>	<b>Retail:</b> \$5/\$9/\$9 <a href="#">copayment</a> + 30% <a href="#">coinsurance</a> <b>Mail:</b> Not covered	<ul style="list-style-type: none"> <li>Some prescriptions are subject to preapproval, quantity limits or step therapy requirements.</li> <li>Penalties for failure to obtain precertification of drugs or dispense as written (DAW) specifications do not count toward the <a href="#">out-of-pocket limit</a>.</li> <li>Certain <a href="#">preventive care</a> drugs mandated by Health Reform are payable at no charge with a prescription.</li> </ul>
	Preferred brand drugs (30/60/90-day supply)	<b>Retail/Mail:</b> \$15/\$27/\$27 <a href="#">copayment</a>	<b>Retail:</b> \$15/\$27/\$27 <a href="#">copayment</a> + 30% <a href="#">coinsurance</a> <b>Mail:</b> Not covered	
	Non-preferred brand drugs (30/60/90-day supply)	<b>Retail/Mail:</b> \$15/\$27/\$27 <a href="#">copayment</a>	<b>Retail:</b> \$15/\$27/\$27 <a href="#">copayment</a> + 30% <a href="#">coinsurance</a> <b>Mail:</b> Not covered	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.hmsa.com](http://www.hmsa.com).

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 <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a>	<a href="#">Specialty drugs</a> (30-day supply only)	<b>Retail:</b> Subject to the applicable generic/brand name <a href="#">copayments</a> listed above <b>Mail:</b> Not covered	<b>Retail:</b> Subject to the applicable generic/brand name <a href="#">copayments</a> listed above <b>Mail:</b> Not covered	To order specialty drugs, contact Caremark Specialty pharmacy at 1-855-801-8263.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	---none---
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	---none---
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	---none---
	<a href="#">Emergency medical transportation</a> (air or ground)	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Limited to air transport to the nearest adequate hospital within the State of Hawaii, except in certain situations when transportation to the continental U.S. is necessary for critical care in accord with HMSA's medical policy. Certain exclusions apply. Ground transportation to the nearest adequate hospital to treat your illness or injury.
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	---none---
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	---none---
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	---none---
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	---none---
	Inpatient services	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	---none---

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.hmsa.com](http://www.hmsa.com).

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 are pregnant	Office visits (prenatal and postnatal care)	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> or <a href="#">copayment</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge	No charge	150 Visits per Calendar Year
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Services may require <a href="#">preauthorization</a> . Benefits may be denied if <a href="#">preauthorization</a> is not obtained. Excludes cardiac rehabilitation.
	<a href="#">Habilitation services</a>	Not covered	Not covered	<a href="#">Excluded service</a>
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	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 <a href="#">Skilled nursing care</a> , sub-acute care, or long-term acute care.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Services may require <a href="#">preauthorization</a> . Benefits may be denied if <a href="#">preauthorization</a> is not obtained.
	<a href="#">Hospice services</a>	No charge	No charge	---none---
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	<a href="#">Excluded service</a>
	Children's glasses	Not covered	Not covered	Provided under a separate vision plan.
	Children's dental check-up	Not covered	Not covered	Provided under a separate vision plan.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.hmsa.com](http://www.hmsa.com).

## 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            | • Dental care (Child)   | • Routine eye care (Adult)                                       |
| • Cardiac rehabilitation | • Habilitation services | • Routine eye care (Child)                                       |
| • Cosmetic surgery       | • Long-term care        | • Routine foot care  |
| • Dental care (Adult)    | • Private-duty nursing  | • Weight loss programs (except as required by Health Reform Law) |

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- |   |  |   |
|---|--|---|
| • Bariatric surgery   | • Infertility treatment (requires precertification and limited to a one time only benefit for one outpatient procedure while you are an HMSA member) | • Non-emergency care when traveling outside the U.S. For more information, see <a href="http://www.hmsa.com">www.hmsa.com</a> . |
| • Chiropractic care (limited to 20 visits/calendar year from American Specialty Health Network) |  |   |
| • Hearing aids (limited to one hearing aid per ear every 60 months)                             |  |   |

**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 [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 on how 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 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.

For prescription drug appeals you may send your written request to: CVS Caremark Appeals Department MC, P.O. Box 52084, Phoenix, AZ 85072-2084 or fax to 1-866-433-1172 attention – Appeals Dept. For specialty drug appeals, you may send your written request to: CVS Caremark Specialty Guideline Mgmt Appeals Department, 800 Biermann Court, Ste. B, Mt. Prospect, IL 60056 or fax to 1-855-230-5548 attention – Appeals Dept. If you have any questions about prescription drug appeals, you may call CVS Customer Care toll-free at 1-855-801-8263, TDD 711.

**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](#).

**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 section.*

## 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 coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- 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*)

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

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$2,300
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,370</b>

### 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 coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- 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*)

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

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$400
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$620</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- 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*)

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

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$600
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$610</b>

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](https://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](https://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) 776-4672 번으로 연락해 주시기 바랍니다. TTY 711 번으로 전화해 주십시오.

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

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

wōñān. 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.

**Samoaan:** MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auunaga fesoasoan, e fai fua e leai se totoi, mo oe, Telefoni mai: 1 (800) 776-4672 e leai se totoi 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.



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