of Tennessee

# EHB Medical Renewal Benefit Summary

**Group:** CareHarmony, Inc. **Group ID:** 136376 - 1

**Plan Information (HSA Qualified)**

**Plan Name:** Bronze 70S ($5400/$7200/50%) **Network:** Blue Network S **Effective Date:** 04/01/2025

| Benefit Plan Features | Cost In-Network | Cost Out-of-Network[1] |
|---|---|---|
| **Annual Deductible** | | |
| Individual / Family | $5,400 / $10,800 | $10,800 / $21,600 |
| **Annual Out-of-Pocket Maximum (includes copays, coinsurance and deductibles)** | | |
| Individual / Family | $7,200 / $14,400 | $21,600 / $43,200 |
| **Covered Services** | | |
| Preventive Care Services [13] (see below for a list) | Covered at 100% | 50% after Deductible |
| **Practitioner Office Services** | | |
| Primary Care Office Visits | 50% after Deductible | 50% after Deductible |
| Specialist Office Visits | 50% after Deductible | 50% after Deductible |
| Office Surgery [4, 5, 6] | 50% after Deductible | 50% after Deductible |
| Routine Diagnostic Lab, X-Ray & Injections | 50% after Deductible | 50% after Deductible |
| Advanced Radiological Imaging [3, 5, 7] | 50% after Deductible | 50% after Deductible |
| Teladoc Health® Virtual Care | 50% after Deductible | Not Covered |
| **Services Rendered at a Facility (includes professional and facility charges)** | | |
| Inpatient Services [3, 5] | 50% after Deductible | 50% after Deductible |
| Outpatient Surgery [4, 5, 6] | 50% after Deductible | 50% after Deductible |
| Routine Diagnostic Services – Outpatient | 50% after Deductible | 50% after Deductible |
| Advanced Radiological Imaging – Outpatient [3, 5, 7] | 50% after Deductible | 50% after Deductible |
| Other Outpatient Services [8] | 50% after Deductible | 50% after Deductible |
| Urgent Care Center Services | 50% after Deductible | 50% after Deductible |
| Emergency Care Services [10] | $500 + Ded/Coins | $500 + Ded/Coins |
| Emergency Care Advanced Radiological Imaging [7] | 50% after Deductible | 50% after Deductible |
| **Skilled Nursing & Rehabilitation Facility Services [3, 5]** | | |
| Limited to 60 days combined per annual benefit period | 50% after Deductible | 50% after Deductible |
| **Medical Equipment [4, 5]** | | |
| Durable Medical Equipment | 50% after Deductible | 50% after Deductible |
| Prosthetics & Orthotics | 50% after Deductible | 50% after Deductible |
| Hearing Aids [22] | 50% after Deductible | 50% after Deductible |

| Benefit Plan Features (cont.) | Cost In-Network | Cost Out-of-Network[1] |
|---|---|---|
| **Behavioral Health Services** | | |
| Inpatient: Unlimited days per annual benefit period [3, 5] | 50% after Deductible | 50% after Deductible |
| Outpatient: Unlimited days per annual benefit period [14] | 50% after Deductible | 50% after Deductible |
| **Therapy Services** | | |
| Rehabilitative [4, 5, 9] & Habilitative [4, 5, 21]<br>Limits apply; see footnotes | 50% after Deductible | 50% after Deductible |
| **Home Health Care Services [4, 5, 9, 21]** | | |
| Home Health Care Services | 50% after Deductible | 50% after Deductible |
| **Hospice Services [5, 23]** | | |
| Hospice Services | 50% after Deductible | 50% after Deductible |
| **Ambulance Services [4]** | | |
| Ambulance Services | 50% after Deductible | 50% after Deductible |
| **Prescription Drugs [4, 11, 12, 16, 18, 20]** | | |
| Prescription Contraceptives [16] | Covered at 100% | 50% after Deductible |
| **Retail Network, Plus90, or Home Delivery Network [15]** | | |
| Generic | 50% after Deductible | 50% after Deductible |
| Preferred | 50% after Deductible | 50% after Deductible |
| Non-Preferred | 50% after Deductible | 50% after Deductible |
| **Self-Administered Specialty Drugs [17, 24]** | | |
| Preferred Specialty Pharmacy Network | 50% after Deductible | Not Covered |
| **Provider-Administered Specialty Drugs [4, 17]** | | |
| Preferred Specialty Pharmacy Network | 50% after Deductible | Not Covered |

## Notes

1. Out-of-network benefits may be based on BlueCross BlueShield of Tennessee maximum allowable charge. You may be responsible for any unpaid billed charges for certain services received from out-of-network providers. For emergency care services received at an out-of-network facility, covered items and services received from an out-of-network provider at an in-network facility (unless you give certain providers written consent), or emergent and authorized air ambulance services, in-network benefits including deductible will apply up to the qualified payment amount, and the provider may not bill you for more than your in-network cost share.
2. The lower copay applies to Family Medicine, General Practice, General Internal Medicine, OB/GYN, Pediatrics, and Behavioral Health services. The copay for Physician Assistants or Nurse Practitioners may be based on the provider type of the billing provider.
3. Prior authorization is required.
4. Certain procedures, services, medication and equipment may require prior authorization.
5. If prior authorization is required but not obtained and services are medically necessary, when using network providers outside Tennessee for physician and outpatient services and all services from out-of-network providers, benefits will be reduced to 50%. If services are not medically necessary, no benefits will be provided.
6. Surgeries include incisions, excisions, biopsies, injection treatments, fracture treatments, applications of casts and splints, sutures and invasive diagnostic services (e.g. colonoscopy, sigmoidoscopy and endoscopy for non-preventive purposes).
7. Includes CT scans, PET scans, MRIs, nuclear medicine and other similar technologies.
8. Includes services such as chemotherapy, infusions, injections, radiation therapy and renal dialysis.
9. Physical, speech, acupuncture, spinal manipulation and occupational therapies are limited to 20 visits per therapy type per annual benefit period. Cardiac and pulmonary rehabilitative therapies are limited to 36 visits per therapy type per annual benefit period.
10. Copay, if applicable, waived if admitted to hospital.
11. Visit www.bcbst.com/rx for the Essential Formulary which includes specialty drugs.
12. Copay, if applicable, applied per prescription, up to a 30 day supply.
13. Services include annual physical, childhood immunizations, recommended adult immunizations and vision and hearing screenings performed by the physician during the preventive health exam.
14. Outpatient behavioral health benefits are determined by place of service. Benefits displayed are for services received in an office setting; separate benefits may apply for outpatient services received in an alternate setting.
15. Your plan requires you to receive long-term medications in a 90 day supply from home delivery or at a retail pharmacy in the Plus90 Network. If you choose to use a retail pharmacy that is not part of the Plus90 Network, you are limited to a 30 day supply. Visit www.bcbst.com/rx to find a list of pharmacies in the Plus90 Network.
16. Certain prescription drugs are covered at 100% at network pharmacies, in accordance with the Preventive Services provision of the Affordable Care Act and are identified on the drug formulary with an "ACA" indicator. Visit www.bcbst.com/rx for the Essential Formulary.
17. You have a distinct network for self-administered specialty drugs and provider-administered specialty drugs. To receive benefits, you must use a Preferred Specialty Pharmacy Network provider. Visit www.bcbst.com/rx for a list of providers in the Preferred Specialty Pharmacy Network. Self-administered specialty drugs are limited to a 30 day supply.
18. If applicable, the 90-day supply copay is reduced to 2.5x the 30-day supply copay. Visit bcbst.com to find a list of pharmacies in the Plus90 Network.
19. If applicable, this plan provides copays for preventive care medications instead of having to meet your plan’s deductible for certain prescription drugs. This list contains some of the most commonly prescribed preventive care drugs and is not all-inclusive. Visit www.bcbst.com/rx for the Essential Plus Formulary.
20. A financial penalty may be applied if you choose a brand name drug when a generic equivalent is available. Please refer to your Evidence of Coverage (EOC) for specific information.
21. Therapy Services - Habilitative: Physical, speech and occupational therapies are limited to 20 visits per therapy type per annual benefit period.
22. Limited to 1 per ear every 3 years.
23. Inpatient Hospice requires prior authorization.
24. If you receive copay assistance that discounts the cost of certain specialty drugs, the plan may reduce the benefits it provides in proportion to the amount of the copay assistance. Additionally, the plan may exclude from accumulation toward any deductible or out-of-pocket maximum the value of any copay assistance applied to any copayment, deductible and/or coinsurance that the plan would require you to pay if you did not receive the copay assistance.

**Limitations and Exclusions:** These pages summarize the benefits of your health care plan. Your Evidence of Coverage (EOC) defines the full terms and conditions in greater detail. Should any questions arise concerning benefits, the EOC will govern. For a complete list of limitations and exclusions, please refer to your EOC.

of Tennessee

# Summary of Preventive Care Services Covered at 100%

**Group:** CareHarmony, Inc. **Group ID:** 136376 - 1

## Plan Information (HSA Qualified)

**Plan Name:** Bronze 70S ($5400/$7200/50%)

**In-network preventive care services that are covered with no member cost share include, but are not limited to:**

- Primary care services with an A or B recommendation by the United States Preventive Services Task Force (USPSTF)
- Immunizations recommended by the Advisory Committee on Immunization Practices that have been adopted by the Centers for Disease Control and Prevention (CDC)
- Bright Futures recommendations for infants, children and adolescents that are supported by the Health Resources and Services Administration (HRSA)
- Preventive care and screening for women as provided in the guidelines supported by HRSA

**The following preventive care services are covered (not an all-inclusive list). Coverage of some services may depend on age and/or risk exposure.**

### All Members:

- One preventive health exam per annual benefit period; more frequent preventive exams are covered for children up to age 3
- All standard immunizations adopted by the CDC
- Screening for colorectal cancer (age 45 – 75), high cholesterol and lipids (age 45 and older for women; age 35 and older for men), high blood pressure, obesity, diabetes and depression (age 12 and older)
- Screening for lung cancer for adults (age 50 - 80) who have a 30 pack-year smoking history and either currently smoke or have quit within the past 15 years, per annual benefit period
- Screening for HIV and certain sexually transmitted diseases and counseling for the prevention of sexually transmitted diseases
- Screening and counseling in primary care setting for alcohol misuse and tobacco use; alcohol misuse and tobacco cessation counseling limited to 8 visits per type per annual benefit period
- Dietary counseling for adults with hyperlipidemia, hypertension, type 2 diabetes, obesity, coronary artery disease and/or congestive heart failure; limited to 12 visits per annual benefit period
- One retinopathy screening for diabetics per annual benefit period
- Hemoglobin (A1C) testing

### Women:

- Well-woman visit, including annual sexually transmitted infection (STI) counseling and annual domestic violence screening & counseling per annual benefit period
- Cervical Cancer Screening as deemed clinically appropriate by USPSTF and HRSA guidelines
- Screening of pregnant women for iron deficiency, bacteriuria, hepatitis B virus, Rh factor incompatibility, gestational diabetes
- Breastfeeding support/counseling and supplies, including lactation support services and counseling by a trained provider and one breast pump per pregnancy
- Counseling women at high risk of breast cancer for chemoprevention, including risks and benefits
- Mammography screening (age 40 and older) and genetic counseling and, if indicated after counseling, BRCA testing for BRCA breast cancer gene
- Osteoporosis screening (age 60 and older)
- HPV testing as deemed clinically appropriate by USPSTF and HRSA guidelines
- FDA-approved contraceptive methods and counseling
- **Medical plan:** Injectable or implantable contraceptives and barrier methods, sterilization for women
- **Rx plan:** Generic oral & injectable contraceptives, vaginal contraceptive, patch, prescription emergency contraception

### Men:

- Prostate cancer screening
- One-time abdominal aortic aneurysm screening (age 65 – 75 for men who have ever smoked)

### Children:

- Newborn screening for hearing, phenylketonuria (PKU), thyroid disease, sickle cell anemia and cystic fibrosis
- Development delays and autism screening
- Iron deficiency screening
- Vision screening

## Pediatric Dental [2]

| Benefit Plan Features | Your Cost In-Network | Your Cost Out-of-Network [1] |
|---|---|---|
| **Coverage A** | | |
| Diagnostic and Preventive Services<br>Exams<br>Cleanings<br>X-Rays | No Member Cost Share | No Member Cost Share |
| **Coverage B** | | |
| Basic Restorative Services<br>Basic Endodontics and Periodontics<br>Oral Surgery | 20% | 20% |
| **Coverage C** | | |
| Major Restorative and Prosthodontics<br>Major Endodontics and Periodontics<br>Implants | 50% | 50% |
| **Coverage D (Requires Prior Authorization)** | | |
| Medically Necessary Orthodontia | 50% after Deductible | 50% after Deductible |

## Pediatric Vision [2]

| Benefit Plan Features | Your Cost In-Network | Your Cost Out-of-Network [1] |
|---|---|---|
| **Exams [3]** | | |
| Comprehensive Eye Exam<br>Contact Lens Fitting and Follow-Up (limited to two) | No Member Cost Share | 40% |
| **Frames [4]** | | |
| Designated available frame at provider location | No Member Cost Share | 40% |
| **Standard Lenses (Glass or Plastic) [3, 4]** | | |
| Single<br>Bifocal<br>Trifocal<br>Lenticular<br>Standard Progressive | No Member Cost Share | 40% |
| **Lens Options [3, 4]** | | |
| Standard Polycarbonate<br>UV Treatment<br>Tint<br>Standard Plastic Scratch Coating<br>Photochromic / Transitions Plastic | No Member Cost Share | 40% |
| **Contacts (includes materials only) [3, 4]** | | |
| Extended Wear / Extended Wear Disposables<br>Daily Wear / Disposables | No Member Cost Share | 40% |

## Notes

1. Out-of-network benefit payment based on maximum allowable charge. You are responsible for paying any amount exceeding the maximum allowable charge.
2. Coverage for members under age 19 only.
3. Vision exams, eyeglass frames and lenses, and contact lenses are covered once every annual benefit period. Prescription sunglasses will be handled as any other lens.
4. Certain restrictions apply.

**Limitations and Exclusions:** These pages summarize the benefits of your health care plan. Your Evidence of Coverage (EOC) defines the full terms and conditions in greater detail. Should any questions arise concerning benefits, the EOC will govern. For a complete list of limitations and exclusions, please refer to your EOC.

BlueCross BlueShield of Tennessee (BlueCross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex[1]. BlueCross does not exclude people or treat them less favorably because of race, color, national origin, age, disability or sex.

BlueCross:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as: (1) qualified sign language interpreters and (2) written information in other formats, such as large print, audio and accessible electronic formats.
- Provides free language assistance services to people whose primary language is not English, such as: (1) qualified interpreters and (2) information written in other languages.

If you need these reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact a consumer advisor at the number on the back of your Member ID card or call 1-800-565-9140 (TTY: 1-800-848-0298 or 711).

If you believe that BlueCross has 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 ("Nondiscrimination Grievance"). For help with preparing and submitting your Nondiscrimination Grievance, contact a consumer advisor at the number on the back of your Member ID card or call 1-800-565-9140 (TTY: 1-800-848-0298 or 711). They can provide you with the appropriate form to use in submitting a Nondiscrimination Grievance. You can file a Nondiscrimination Grievance in person or by mail, fax or email. Address your Nondiscrimination Grievance to: Nondiscrimination Grievance; c/o Manager, Operations, Member Benefits Administration; 1 Cameron Hill Circle, Suite 0019, Chattanooga, TN 37402-0019; (423) 591-9208 (fax); Nondiscrimination_OfficeGM@bcbst.com (email).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights,electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201,1–800–368–1019, 800–537–7697 (TDD).Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

You can contact BlueCross's Nondiscrimination Coordinator at 423-535-1010 (TTY: 1-800-848-0298 or 711); Nondiscrimination_CoordinatorGM@bcbst.com (email); or Corporate Compliance, 1 Cameron Hill Circle, 1.4, Chattanooga, TN 37402.

This notice is available at BlueCross's website: bcbst.com.

BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield Association.

BlueCross BlueShield of Tennessee is a Qualified Health Plan Issuer in the Health Insurance Marketplace.

[1] Consistent with the scope of sex discrimination described at 45 CFR 92.101(a)(2))

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Si usted es miembro, llame al número de Servicio de atención a miembros que figura al reverso de su tarjeta de identificación de Miembro o al 1-800-565-9140 (TTY: 1-800-848-0298).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. إذا كنت عضوًا، فاتصل برقم خدمة الأعضاء الموجود على ظهر بطاقة هوية العضو أو بالرقم 1-800-565-9140 (الهاتف النصي: 1-800-848-0298).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。若您是會員，請撥打會員 ID 卡背面的會員服務部號碼或 1-800-565-9140（聽障專線 (TTY)：1-800-848-0298）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Nếu quý vị là hội viên, hãy gọi đến số Dịch vụ Hội viên ở mặt sau thẻ ID Hội viên của quý vị hoặc 1-800-565-9140 (TTY: 1-800-848-0298).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 가입자의 경우, 가입자 ID 카드 뒷면의 가입자 서비스 전화번호 또는 1-800-565-9140(TTY: 1-800-848-0298) 번으로 전화하시기 바랍니다.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes adhérent, appelez le numéro du Service adhérents indiqué au dos de votre carte d'assuré adhérent ou appelez le 1-800-565-9140 (TTY/ATS : 1-800-848-0298).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ,ການບໍລິການຊ່ວຍເຫຼືອດ້ ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ຖ້າທ່ານເປັນ ສະມາຊິກ, ໃຫ້ໂທຫາເບີ ໂທລະສັບບໍລິການສະມາຊິກທີ່ມີຢູ່ດ້ານຫຼັງບັດ ID ສະມາຊິກຂອງ ທ່ານ ຫຼື 1-800-565-9140 (TTY: 1-800-848-0298).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገኙት ተዘጋጅተዋል፡ አባል ከሆኑ፣ በአባልነት መታወቂያዎ ጀርባ ላይ በሚገኘው የአባል አገልግሎት ቁጥር ወይም በ 1-800-565-9140 (መስማት ለተሳናቸው፣ TTY: 1-800-848-0298) ይደውሉ።

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Falls Sie ein Mitglied sind, rufen Sie die Nummer des Mitgliederdienstes auf der Rückseite Ihrer Mitglieds-ID-Karte oder 1-800-565-9140 (TTY: 1-800-848-0298) an.

સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. જો તમે સભ્ય છો, તો તમારા સભ્ય આઈડી પાછળના સભ્ય સેવા નંબર પર અથવા 1-800-565-9140 (TTY: 1-800-848-0298) પર કૉલ કરો.

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。会員のお客様は、会員IDカードの裏面に記載の会員サービス番号あるいは1-800-565-9140 (TTY: 1-800-848-0298)まで、お電話にてご連絡ください。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Kung ikaw ay isang miyembro, tawagan ang numero ng Serbisyo sa Miyembro na nasa likod ng iyong Kard ng ID ng Miyembro o sa 1-800-565-9140 (TTY: 1-800-848-0298).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। अगर आप सदस्य हैं तो अपने सदस्य आईडी कार्ड के पीछे दिए गए नंबर या 1-800-565-9140 (TTY: 1-800-848-0298) पर सदस्य सेवा नंबर पर फोन करें।

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Если Вы являетесь участником, позвоните в отдел обслуживания участников по номеру, указанному на обратной стороне Вашей идентификационной карты участника, или по номеру 1-800-565-9140 (TTY: 1-800-848-0298).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. درصورتیکه عضو هستید، با شماره خدمات اعضا در پشت کارت شناسایی عضو خود یا 1-800-565-9140 (TTY: 1-800-848-0298) تماس بگیرید.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Si ou se yon manm, rele nimewo Sèvis Manm ki sou do kat ID Manm ou an oswa 1-800-565-9140 (TTY: 1-800-848-0298).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Członkowie mogą dzwonić pod numer działu Member Service podany na odwrocie karty identyfikacyjnej członka lub numer 1-800-565-9140 (TTY: 1-800-848-0298).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Caso seja membro, ligue para o telefone do serviço de Atendimento ao Membro informado no verso de seu cartão de identificação de membro ou para 1-800-565-9140 (TTY: 1-800-848-0298).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Se è un membro, chiami il numero del Servizio per i membri riportato sul retro della Sua scheda identificativa del membro oppure il numero 1-800-565-9140 (TTY: 1-800-848-0298).

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló. Naaltsoos bee ná ha'dit'éego, Naaltsoos Bá Hada'dit'éhígíí nínaaltsoos nitł'ízí bee nééhozinígíí bine'dęę' Naaltsoos Bá Hada'dit'éhígíí Bee Aka'anída'awo'í bibéésh bee hane'í bíká'ígíí bee hodíłnih doodago 1-800-565-9140 (Doo Adínits'agóógo g TTY: 1-800-848-0298) bee hodíłnih.

WICHDICH: Wann du Deitsch schwetzscht un witt en Translator, kenne mer eener griege fer dich unni as es dich ennich ebbes koschte zellt. Wann du en Member bischt, ruf der Member Service Number uff as uff die hinnerscht Seit vun dei Member ID Card is odder ruf 1-800-565-9140 (TTY: 1-800-848-0298) uff.

FAAMATALAGA: Afai e te tautala i le Gagana Samoa, o lo'o avanoa mo oe auaunaga fesoasoani i le gagana e leai se totogi. Afai o oe o se sui, fa'amolemole vala'au le numera o le Member Service o lo'o i tua o lau pepa ID po'o le 1-800-565-9140 (TTY: 1-800-848-0298).

ATENSHUN: Gare iga gogal Kapasal Falawasch, ye fri ngalug yamem bwe tepangug rel iye kepat kaale. Nge gare iga gel gosa fasiul log bwe semal member, gosa kol yegili nampal Member Service woal pak rel Member ID kard la yamw gare kol yegili 1-800-565-9140 (TTY: 1-800-848-0298).

ATENSION: Kumu un tungo fuminu' Chamoru, guaha dibatdi na setbision asistimentun lengguahi para hågu. Kumu membro hao, pot fabot agang i Setbision Membro na numeru gi santatin iyomu ID card Membro pat 1-800-565-9140 (TTY: 1-800-848-0298).