



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, call 1-866-494-2111 or visit us at www.cigna.com/ifp-documents. 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 <https://www.healthcare.gov/sbc-glossary/> or call 1-866-494-2111 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$0 person/ \$0 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. Preventive care and other services indicated in chart starting on page 2.	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 ?	\$2,400 person/ \$4,800 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums , balance-billing charges, penalties for failure to obtain preauthorization for 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 www.cigna.com/ifp-providers or call 1-866-494-2111 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.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .

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	\$5 copayment /visit	Not covered	Refer to the policy for more information about Virtual Care Services.
	Specialist visit	\$15 copayment /visit	Not covered	None.
	Preventive care/screening /immunization	No charge	Not covered	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.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	Not covered	None.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	Not covered	None.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.cigna.com/ifp-drug-list	Generic drugs	Preventive drugs: No charge (retail/home delivery). Generic: \$5 copayment (retail) / \$15 copayment (home delivery).	Not covered	Generic, Preferred, and Non-Preferred Drugs: Limited to up to a 30-day supply (retail) or a 90-day supply (designated 90-day retail pharmacy/home delivery). You pay a copayment for each 30-day supply (retail), if applicable. Specialty drugs : Limited to up to a 30-day supply (retail) or a 30-day supply (designated 90-day retail pharmacy/home delivery). Cigna Healthcare's specialty pharmacy can assist you in obtaining your specialty drugs . Call Accredo, at 1-877-826-7657 to talk to a representative.
	Preferred brand drugs	\$25 copayment (retail) / \$75 copayment (home delivery)	Not covered	
	Non-preferred drugs	\$200 copayment (retail) / \$600 copayment (home delivery)	Not covered	
	Specialty drugs and other high cost drugs	40% coinsurance (retail)/30% coinsurance (home delivery)	Not covered	

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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered	None.
	Physician/surgeon fees	10% coinsurance	Not covered	None.
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	You pay the same level as In-Network if it is an emergency as defined in your plan , otherwise Not covered
	Emergency medical transportation	10% coinsurance	10% coinsurance	
	Urgent care	\$25 copayment /visit	\$25 copayment /visit	Emergency medical transportation services for MH/SA diagnoses will be payable according to emergency room care benefits.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not covered	None.
	Physician/surgeon fees	10% coinsurance	Not covered	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: \$15 copayment /visit. All other outpatient services: 10% coinsurance .	Not covered	Includes medical services for MH/SA diagnoses.
	Inpatient services	10% coinsurance	Not covered	Includes medical services for MH/SA diagnoses.
If you are pregnant	Office visits	10% coinsurance	Not covered	Cost sharing does not apply for preventive services . Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	10% coinsurance	Not covered	
	Childbirth/delivery facility services	10% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Not covered	Coverage is limited to 28 hours per week.
	Rehabilitation services	\$5 copayment /visit for physical, occupational and chiropractic therapy; 10% coinsurance for speech therapy.	Not covered	Coverage of physical, occupational and chiropractic therapy is unlimited annual max. Speech therapy is limited to 20 visit annual max.
	Habilitation services	10% coinsurance	Not covered	Coverage is limited to 20 visits annual max per therapy.

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)	
	Skilled nursing care	10% coinsurance	Not covered	Coverage is limited to 100 days annual max.
	Durable medical equipment	10% coinsurance	Not covered	None.
	Hospice services	10% coinsurance	Not covered	None.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Children up to age 19, through the end of their birth month. Coverage limited to one exam/year.
	Children's glasses	No charge	Not covered	Children up to age 19, through the end of their birth month. Coverage limited to one pair of glasses (lenses and frames from pediatric selection), per every two years.
	Children's dental check-up	Not covered	Not covered	

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 .)			
• Cosmetic surgery • Dental care (Adult)	• Long-term care • Non-emergency care when traveling outside the U.S.	• Routine eye care (Adult) • 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.)	
• Abortion • Acupuncture • Bariatric surgery • Chiropractic care	• Hearing aids (limited to 1 hearing aid per ear every 3 years, to age 18) • Infertility treatment • Private duty nursing

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: Colorado Department of Insurance at 1-800-930-3745. 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. For more information on your rights to continue coverage, contact the insurer at 1-866-494-2111.

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: Colorado Department of Insurance at 1-800-930-3745.

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](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-494-2111.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-494-2111.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-866-494-2111.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-866-494-2111.

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 copayment	\$15
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$10
Coinsurance	\$1,300

<i>What isn't covered</i>	
Limits or exclusions	\$60

The total Peg would pay is	\$1,370
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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	\$15
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$500
Coinsurance	\$90

<i>What isn't covered</i>	
Limits or exclusions	\$20

The total Joe would pay is	\$610
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Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$15
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

This EXAMPLE event includes services like:

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

Total Example Cost	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$70
Coinsurance	\$200

<i>What isn't covered</i>	
Limits or exclusions	\$0

The total Mia would pay is	\$270
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The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Colorado Supplement to the Summary of Benefits and Coverage Form

INSURANCE COMPANY NAME	Cigna Health and Life Insurance Company
NAME OF PLAN	Cigna Connect Flex Silver 3500 (100-150% FPL)
1. Type of Policy	Individual Policy
2. Type of plan	Exclusive provider organization (EPO)
3. Areas of Colorado where plan is available.	Plan is available only in the following areas: Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Jefferson, Larimer, Teller, Weld

SUPPLEMENTAL INFORMATION REGARDING BENEFITS

Important Note: The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. It provides additional information meant to supplement the Summary of Benefits of Coverage you have received for this plan. This plan may exclude coverage for certain treatments, diagnoses, or services not specifically noted. Consult the actual policy to determine the exact terms and conditions of coverage.

	Description
4. Annual Deductible Type	EMBEDDED DEDUCTIBLE INDIVIDUAL – The amount that each member of the family must meet prior to claims being paid. Claims will not be paid for any other individual until their individual deductible or the family deductible has been met. FAMILY – The maximum amount that the family will pay for the year. The family deductible can be met by any number of individuals.
5. Out-of-Pocket Maximum	EMBEDDED OUT-OF-POCKET INDIVIDUAL – The amount that each member of the family must meet prior to claims being paid at 100%. Claims will not be paid at 100% for any other individual until their individual out-of-pocket or the family out-of-pocket has been met.

	FAMILY – The maximum amount that the family will pay for the year. The family out-of-pocket can be met by any number of individuals.
6. What is included in the In-Network Out-of-Pocket Maximum?	Deductibles, Copayments and Coinsurance As specified in § 10-16-161, C.R.S., effective for all health benefit plans issued or renewed on or after January 1, 2025, all carriers shall include any amount paid by the covered person and/or by another person on behalf of the covered person for a prescription drug when calculating the covered person's overall contribution to an out-of-pocket maximum or cost-sharing requirement.
7. Is pediatric dental covered by this plan?	No, the plan does not include pediatric dental
8. What cancer screenings are covered?	Breast Cancer Screening with Mammography, Cervical Cancer Screening, Colorectal Cancer Screening, Prostate Cancer Screening

USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
9. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	N/A
10. Does the plan have a binding arbitration clause?	No	

Questions: Call 1-800-244-6224 or visit us at www.cigna.com.

ATENCIÓN: tiene a su disposición servicios gratuitos de asistencia lingüística. **Si es un cliente actual de Cigna,** llame al número que figura en el reverso de su tarjeta de identificación. **Si no lo es, llame al 1-800-244-6224** (los usuarios de TTY deben llamar al 711).

If you are not satisfied with the resolution of your complaint or grievance, contact:

Colorado Division of Insurance
Consumer Services, Life and Health Section
1560 Broadway, Suite 850, Denver, CO 80202
Call: 303-894-7490 (in-state, toll-free: 800-930-3745)
Email: dora_insurance@state.co.us

Discrimination is against the law

Cigna Healthcare® complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes.

Cigna Healthcare does not exclude people or treat them less favorably differently because of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes.

Cigna Healthcare:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids 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 free language assistance services to people whose primary language is not English in a timely manner, such as:
 - Qualified interpreters
 - Information written in other languages



Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company, Evernorth Behavioral Health, Inc., Evernorth Care Solutions, Inc., Cigna Dental Health, Inc., and HMO or service company subsidiaries of Cigna Health Corporation, including Cigna HealthCare of Arizona, Inc., Cigna HealthCare of Georgia, Inc., Cigna HealthCare of Illinois, Inc., Cigna HealthCare of North Carolina, Inc., and Cigna HealthCare of Texas, Inc. In Texas, the Dental plan is known as Cigna Dental Choice, and this plan uses the national Cigna DPPO Advantage network. ATTENTION: If you speak languages other than English, language assistance service, free of charge are available to you. For current Cigna Healthcare customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711). ATENCIÓN: Si usted habla un idioma que no sea inglés, tiene a su disposición servicios gratuitos de asistencia lingüística. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

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If you need reasonable modifications, appropriate auxiliary aids and services or language assistance services, contact the Civil Rights Coordinator.

If you believe that Cigna Healthcare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes, you can file a grievance with the Civil Rights Coordinator

P.O. Box 188016, Chattanooga, TN 37422,
877.822.6561 (TTY: Dial 711)

ACAGrievance@CignaHealthcare.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights 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>, 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
<https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html>

Proficiency of Language Assistance Services

English – ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-244-6224 (TTY: Dial 711) or speak to your provider.

Spanish – ATENCIÓN: Si habla español, los servicios de asistencia lingüística gratuitos están disponibles para usted. También están disponibles de forma gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 1-800-244-6224 (TTY: Marque 711) o hable con su proveedor.

Chinese – 注意: 如果您讲中文，我们提供免费的语言援助服务。适当的辅助设备和服务也可以免费提供，以提供无障碍格式的信息。请拨打 1-800-244-6224 (TTY: 拨打 711) 或与您的服务提供者联系。

Vietnamese – XIN LƯU Ý: Nếu bạn nói tiếng Viet, dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho bạn. Các thiết bị và dịch vụ hỗ trợ phù hợp để cung cấp thông tin ở định dạng có thể tiếp cận cũng có sẵn miễn phí. Gọi số 1-800-244-6224 (TTY: Gọi 711) hoặc nói chuyện với nhà cung cấp của bạn).

Korean – 주의: 한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 기기 및 서비스도 무료로 제공됩니다. 1-800-244-6224 (TTY: 711 로 전화) 로 전화하시거나 제공자에게 문의하십시오.

Tagalog – PAUNAWA: Kung ikaw ay nagsasalita ng Tagalog, ang mga libreng serbisyo ng tulong sa wika ay magagamit para sa iyo. Ang mga angkop na pantulong na kagamitan at serbisyo upang magbigay ng impormasyon sa mga naa-access na format ay magagamit din ng libre. Tumawag sa 1-800-244-6224 (TTY: Tumawag sa 711) o makipag-usap sa iyong tagapagbigay.

Russian – ВНИМАНИЕ: Если вы говорите на русском, доступны бесплатные услуги языковой помощи. Также бесплатно предоставляются соответствующие вспомогательные средства и услуги для предоставления информации в доступных форматах. Позвоните по телефону 1-800-244-6224 (TTY: Наберите 711) или обратитесь к вашему провайдеру.

Arabic - تنبيه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر أيضًا مساعدات قابلة للوصول إليها، وذلك مجانًا. اتصل بالرقم 1-800-244-6224 (TTY: اطلب 711) أو تحدث إلى مقدم الخدمة الخاص بك (اطلب 711).

French Creole – ATANSYON: Si ou pale Kreyòl Ayisyen, sèvis asistans lang gratis yo disponib pou ou. Ekipman ak sèvis adisyonèl ki apwopriye pou bay enfòmasyon nan fòm ki aksesib yo disponib tou gratis. Rele 1-800-244-6224 (TTY: Rele 711) oswa pale ak founisè ou a.

French – ATTENTION : Si vous parlez français, des services d'assistance linguistique gratuits sont disponibles pour vous. Des aides et des services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-244-6224 (TTY : composez le 711) ou parlez à votre fournisseur.

Portuguese – ATENÇÃO: Se você fala português, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-244-6224 (TTY: disque 711) ou fale com seu prestador de serviços.

Polish – UWAGA: Jeśli mówisz po polsku, dostępne są bezpłatne usługi pomocy językowej. Odpowiednie pomoce i usługi wspierające w celu dostarczenia informacji w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-800-244-6224 (TTY: wybierz 711) lub skontaktuj się ze swoim dostawcą usług.

Japanese – 注意: 日本語を話す場合は、無料の言語支援サービスが利用できます。アクセス可能な形式で情報を提供するための適切な補助機器やサービスも無料で利用できます。1-800-244-6224 (TTY: 711 にダイヤル) に電話するか、提供者に話してください。

Italian – ATTENZIONE: Se parli italiano, sono disponibili per te servizi gratuiti di assistenza linguistica. Sono disponibili gratuitamente anche ausili e servizi appropriati per fornire informazioni in formati accessibili. Chiama il numero 1-800-244-6224 (TTY: componi il 711) o parla con il tuo fornitore.

German – Achtung: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Geeignete Hilfsmittel und Dienste, um Informationen in barrierefreien Formaten bereitzustellen, sind ebenfalls kostenlos verfügbar. Rufen Sie 1-800-244-6224 an (TTY: Wählen Sie 711) oder sprechen Sie mit Ihrem Anbieter.

Persian (Farsi) - همچنین، وسایل و خدمات کمکی مناسب برای در دسترس است. خدمات رایگان کمک زبان برای شما صحبت می‌کنند، توجه: اگر به فارسی تماس بگیرید یا با (شماره 711 را بگیرید (TTY: ارائه اطلاعات در قالبهای قابل دسترس به صورت رایگان در دسترس هستند. با شماره 1-800-244-6224. ارائه‌دهنده خود صحبت کنید