CommunityCare™ 25 Years

Benefits Booklet

Tulsa FOP 93 Health & Welfare Trust

PPO (Out of Area)

Effective Date: 7/1/2018

Welcome

Thank you for choosing CommunityCare as your health insurance Third Party Administrator. Our goal is to provide you with the highest level of service possible. We are also committed to offering you providers in our networks who deliver high quality care and services.

Questions?

Phone

Member Services: **(918) 594-5201** or **(800) 777-4890**

Medalist Rx: **(855) 633-2579**

Email

ccare@ccok.com

Online

Visit our website at http://fop.ccok.com to register for a secure login to access the following resources through Member Connection:

- Access visits and claims history
- View your Explanation of Benefits statements (EOB) online
- View your deductible and out-of-pocket summary
- Provider and facility searches
- Member handbook and benefit materials
- Print temporary member ID cards
- Order replacement ID cards
- Popular forms & resources
- Wellness resources and more

Save Paper

Paperless Explanation of Benefits (EOB) statements

CommunityCare offers you electronic paperless EOBs. Once you register for on the Member Connection secure portal access, you will be prompted to "Go Paperless." If you choose this option, you will receive an email when you have an EOB ready to view in Member Connection.

How to Find a Physician Online

Go to the CommunityCare website at http://fop.ccok.com and follow these steps to search for a doctor:

Step 1: From the home page, click **Benefit Details**.

Step 2: Click the desired plan.

Step 3: Click either the **CommunityCare PPO Standard Network** or the **PHCS / Multiplan Provider Search (for outside of Oklahoma only)** link.

24-Hour Nurse Line

- A free, 24-hour nurse staffed information line is available for CommunityCare members
- You may speak to a registered nurse who can recommend a proper course of treatment for medical conditions or problems
- Features an audio health library with more than 400 topics

Call the 24-hour nurse line at **(800) 777-4890.**

Wellness Resources

CommunityCare offers online tools and resources to help with your health and wellness goals available at http://fop.ccok.com:

- Take the free General Health Assessment to evaluate your overall health and wellness. The General Health Assessment is a health and lifestyle questionnaire that takes less than 30 minutes to complete.
- Check out the health encyclopedia, symptom checker, wellness calculators and more.

Coordination Of Benefits

What does "Coordination of Benefits" (COB) mean?

Your CommunityCare health plan has a COB provision. This provision applies when **you or your dependents are covered for benefits under more than one health plan.**

It is the responsibility of our members to advise us of their participation in any other health plan. CommunityCare will request information from you about other health coverage during your initial enrollment and then annually at your group's renewal.

If a response is not received within the required timeframe, CommunityCare may hold payment of your claims until we can confirm the possibility of dual coverage for yourself or your covered dependent. Please be sure to respond to the COB request in a timely manner to avoid any disruption in your claims payment.

The COB form can be found on the ComunityCare website: http://fop.ccok.com.

You can return the form by mail or by calling member services at (918) 594-5201 or (800) 777-4890.

No Referrals!

CommunityCare members may set up an appointment with specialty care physicians in their network **without a referral** from their primary care physician (PCP).

Emergency Care

If an emergency threatens life or limb, go immediately to the nearest emergency room. If you receive out-of-network emergency care services, you may want to contact your PCP to coordinate any follow-up care.

Urgent Care

You might need urgent care if your illness or injury is severe enough to need treatment within 24 hours. If you receive out-of-network urgent care services, you may want to contact your PCP to coordinate any follow-up care.

Preventive Care

Preventive care services, including an annual physical, annual well woman exam and an annual vision screening, are covered benefits.

CommunityCare™ Employer's Choice

PPO Out-of-Area Plan

	In-Network	Out-of-Network
Calendar Year Deductible		
Per Member	$1,000	$2,000
Per Family	$2,000	$4,000
Out-of-Pocket Limit Per Calendar Year (does not include deductible)		
Per Member	$1,500	$3,000
Per Family	$3,000	$6,000
Physician Services		
(Additional Coinsurances/Copayments may apply)		
Primary Care Office Visits	$40 Copayment per Visit	50% Coinsurance *
Specialty Care Office Visits	$50 Copayment per Visit	50% Coinsurance *
Preventive Care	No Copayment	50% Coinsurance *
(Please see your Certificate for details)		
Emergency Care and Urgent Care		
(Additional Coinsurances/Copayments may apply) (Benefits will be denied if not medically necessary)		
Hospital Emergency Room	20% Coinsurance *	20% Coinsurance *
Urgent Care Facility	$60 Copayment per Visit	50% Coinsurance *
Inpatient Hospital Care		
Room and Board	20% Coinsurance *	50% Coinsurance *
(Including all other medically necessary services)		
Mental Health, Alcohol and Drug Services		
Inpatient	20% Coinsurance *	50% Coinsurance *
Outpatient	$40 Copayment per Visit	50% Coinsurance *
Outpatient Surgery		
Primary Care Office Visits	$40 Copayment per Visit	50% Coinsurance *
Specialty Care Office Visits	$50 Copayment per Visit	50% Coinsurance *
Outpatient Surgical Facility	20% Coinsurance *	50% Coinsurance *

*After Deductible, the Coinsurance/Copayment will apply.
^See prescription drug benefit plan for additional information.

Outpatient Diagnostic Services		
(Additional Coinsurances/Copayments may apply, regardless of where outpatient services are rendered)		
Laboratory	No Additional Copayment	50% Coinsurance *
Outpatient Radiology	No Additional Copayment	50% Coinsurance *
MRI, CT Scan and PET Scan	20% Coinsurance *	50% Coinsurance *
Rehabilitation Therapy		
(Up to 60 treatment visits per benefit type)		
Inpatient Rehabilitation	20% Coinsurance *	50% Coinsurance *
Outpatient Physical, Occupational and Speech Therapy	$50 Copayment per Visit	50% Coinsurance *
Other Covered Services		
(Quantity limits may apply)		
Allergy Serum/Injections	Subject to the PCP or Specialist Copayment	50% Coinsurance *
Allergy Testing & Treatment	If an office visit is charged, subject to the PCP or Specialist office visit Copayment	50% Coinsurance *
Allergy Testing & Treatment not in a Physician's Office	20% Coinsurance *	50% Coinsurance *
Ambulance	20% Coinsurance *	20% Coinsurance *
(Emergency only)		
Chiropractic Care	20% Coinsurance *	50% Coinsurance *
(Limited to a total of 60 visits per calendar year to include direct contracts and insurance contracts combined)		
Diabetic Supplies	20% Coinsurance *	50% Coinsurance *
Durable Medical Equipment	20% Coinsurance *	50% Coinsurance *
Fertility Evaluation	20% Coinsurance *	Not Covered
General Anesthesia *(for eligible dental procedures only)*	20% Coinsurance *	50% Coinsurance *
Hearing Aids (Children under the age of 19)	20% Coinsurance *	50% Coinsurance *
Home Health Services	20% Coinsurance *	50% Coinsurance *
Hospice Care	20% Coinsurance *	50% Coinsurance *
(Inpatient requires pre-certification)		
Immunosuppressives, Injectables (except immunizations) and Drugs administered in the physician's office	20% Coinsurance *	50% Coinsurance *

*After Deductible, the Coinsurance/Copayment will apply.
^See prescription drug benefit plan for additional information.

Infusion		
(Must be medically necessary and may be subject to prior authorization)		
Administered in a physician's office	$50 Copayment per Visit	50% Coinsurance *
(Except for specialty drugs within this category - see Specialty Drugs below)		
Administered in an outpatient facility	20% Coinsurance *	50% Coinsurance *
Administered in a home setting	20% Coinsurance *	50% Coinsurance *
(Except for specialty drugs within this category - see Specialty Drugs below)		
Organ Transplants *(Must be medically necessary and may be subject to prior authorization)*	20% Coinsurance *	Not Covered outside the Transplant Network
Orthotics and Prosthetics	20% Coinsurance *	50% Coinsurance *
Ostomy and Urologic Supplies	20% Coinsurance *	50% Coinsurance *
Prescription Drug Benefit	See Outpatient Prescription Drug Benefit ^	Not Covered
Radiation Therapy	20% Coinsurance *	50% Coinsurance *
Skilled Nursing Facility Care	20% Coinsurance *	50% Coinsurance *
(Up to 60 treatment days per disability per calendar year)		
Specialty Drugs from a medical provider	20% Coinsurance *	50% Coinsurance *
(Must be medically necessary and may be subject to prior authorization)		
All Other Covered Services	20% Coinsurance *	50% Coinsurance *

*After Deductible, the Coinsurance/Copayment will apply.
^See prescription drug benefit plan for additional information.

Comments

- Deductible must be satisfied before Coinsurance begins, where it applies.
- Copayments do not apply toward the deductible.
- Prescription drugs and non-covered items do not apply toward the medical calendar year deductible.
- Expenses incurred during the last three months of the calendar year and applied to the current year's deductible may be used to help meet the deductible requirement of the next year.
- Any number of members of the family may combine to meet two times the individual medical deductible to satisfy the family medical deductible requirement.
- All covered medical out-of-pocket expenses are applied toward your medical out-of-pocket limit. Your total out-of-pocket limit equals your medical out-of-pocket amount plus your deductible. Please note: Your prescription drug out-of-pocket expenses will accrue toward a seperate prescription drug out-of-pocket limit.
- A calendar year is defined as the time period from January 1 - December 31.
- Deductible amounts and out-of-pocket limitations are separate for in-network provider and out-of-network provider benefits.

Out-of-Network Requirements

- All out-of-network provider calculations are based on the out-of-network fee schedule as described in your Handbook. The enrollee is also responsible for any amount charged by a provider in excess of the out-of-network fee schedule.
- Call the phone number on the back of your ID card before an elective surgery or 7 days in advance of a hospital stay arranged through a non-network healthcare provider. Failure to follow these procedures will result in eligible benefits for out-of-network hospital care or surgery being reduced by $500.
- For emergencies, call your primary care physician for follow-up care.
- "Balance Billed Amounts" do not apply to out-of-pocket limitation.

Urgent and Emergency Care

It is important that you follow-up with your PCP within 48 hours of any Urgent or Emergent Care Services. This will allow your PCP to direct or coordinate all of your follow-up care. Follow-up care that is not arranged by your PCP may not be covered. Your PCP is available 24 hours a day, seven days a week.

If you have an emergency that is considered life or limb threatening, go to the nearest hospital or emergency room. After you have sought emergency care, please notify your PCP to arrange for any follow-up care that may be necessary. Forward any bills to CommunityCare Plus for reimbursement. Consult your Handbook for examples of medical emergencies.

For a list of Exclusions and Limitations, please see Handbook.

THIS IS NOT A CONTRACT. It is intended only as a source of general information and is subject to the terms of your Certificate.

*After Deductible, the Coinsurance/Copayment will apply.
^See prescription drug benefit plan for additional information.

Prescription Drug Schedule of Benefits

Prescription Benefits Do Not Apply To Medical Only Coverage

Pharmacy Only Out-of-Pocket Limit per Calendar Year (includes copayments):

Per Individual	**$2,000**
Per Family	**$4,000**

BENEFIT COPAYMENTS

Some preferred generic drugs have a $0 Copayment. - Reasors Program
Please note that Quantity Limits or Prior Authorization may apply. Refer to your prescription drug formulary guide for additional information. If the cost of the prescription is less than the applicable Copayment, you will only be charged the cost of the prescription.

RETAIL PHARMACY

Up to a 30-day supply for each prescription.

Tier 1 - Preferred Generic Drugs	$15 Copayment
*Tier 2 - Preferred Brand Drugs	$35 Copayment
*Tier 3 - Non-Preferred Brand Drugs	$60 Copayment
	Prescriptions $1,000 or more 20% Coinsurance Copayment
	90-day retail supply available at 3 Copayments.

MAIL ORDER PHARMACY

Up to a 90-day supply for each prescription. Certain prescriptions, including specialty pharmacy drugs, are not eligible for mail order Copayments. Refer to your prescription drug formulary guide for additional information.

Tier 1 - Preferred Generic Drugs	$30 Copayment
*Tier 2 - Preferred Brand Drugs	$70 Copayment
*Tier 3 - Non-Preferred Brand Drugs	$120 Copayment
	Prescriptions $1,000 or more 20% Coinsurance Copayment
	90-day mail order supply available at 2 Copayments.

SPECIALTY PHARMACY

Up to a 30-day supply for each prescription. Refer to your formulary guide for a list of medications covered under the Specialty Pharmacy Program. Specialty Pharmacy Drugs can be obtained from a contracted Specialty Pharmacy Provider.

	$200 Copayment for < $1,000
	Prescriptions $1,000 or more 20% Coinsurance Copayment

Please consult your pharmacy directory for a list of participating pharmacies.
Visit www.medalistrx.com for a Pharmacy directory.
For all other questions, please call MedalistRx™ at (855) 633-2579.

Prescription drugs purchased from an out-of-network pharmacy are not covered.

Please refer to Section I Prescription Drug Benefit Information of this handbook for special Exclusions and Limitations that apply to your prescription drug benefits, and are in addition to the list of Exclusions and Limitations described in Section VI of this handbook.

+Products are excluded except as required by law.
*When a brand medication is selected over its generic equivalent, the member will be responsible for non-preferred brand copayment and the difference in cost.

Non-Discrimination Policy

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

CommunityCare:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact CommunityCare's Senior Manager of Quality Improvement/Compliance. If you believe that CommunityCare 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 with:

CommunityCare

Attn: Senior Manager of Quality Improvement/Compliance

P.O. Box 3249 Tulsa, Oklahoma 74101

(918) 594-5303 (phone)

(918) 594-5250 (Fax)

memberservicesreview@ccok.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, CommunityCare's Senior Manager of Quality Improvement/Compliance 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, D.C. 20201 **1-800-368-1019**, **800-537-7697** (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html .

Multi-Language Interpreter Services - Taglines for Notices

Spanish

Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de CommunityCare. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 1-800-777-4890.

Vietnamese

Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng bàn về đơn nộp hoặc hợp đồng bảo hiểm qua chương trình CommunityCare. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ trúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 1-800-777-4890.

Chinese

本通知有重要的訊息。本通知有關於您透過[插入 SBM 項目的名稱 CommunityCare 提交的申請或 保險的重要訊息。請留意本通知內的重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險　或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話　[在此插入數字1-800-777-4890

Korean

본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 CommunityCare 을 통한 커버리지에 관한 정보를 포함하고 있습니다.

본 통지서에서 핵심이 되는 날짜들을 찾으십시오. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 1-800-777-4890로 전화하십시오.

German

Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch CommunityCare. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 1-800-777-4890.

Arabic

يحوي هذا الاشعار معلومات هامة. يحوي هذا الاشعار معلومات مهمة بخصوص طلبك للحصول على التغطية من خلالCommunityCare. ابحث عن التواريخ الهامة في هذا الاشعار. قد تحتاج لاتخاذ اجراء في تواريخ معينة للحفاظ على تغطيتك الصحية او للمساعدة في دفع التكاليف. لك الحق في الحصور على المعلومات والمساعدة بلغتك من دون أي تكلفة. اتصل ب-1-800-777-4890

Burmese

ဤစာ၌ ေအရးႀကီးေ သာ အြ်ကအလက ပါ၀ငပါသည္ ။ ဤစာ၌ သင ၏ေ လ်ာက္လႊ ာ သည္႔မဟုတ္ CommunityCare င သက္ဆိုင ေ သာ သင ြ်စာ်းခြင အြ်ကအလကမ်ား ပါ၀ငပါသည္ ။ အဓေသကရက္စြဲ ကသု ဤစာ၌ရ ာေ ခဖပ္။ သတ္မွတ္ထားေ သာ ေ နာကဆုံးရက မတိုငမီ ကိန္းမာေ ရးြစာ်းခြင သည္႔မဟုတ္ စရသတ္မြစာ်းခြင ဆကလကရရ သေ ေနစရန ေ ဆာင္ရြကစရာရ သည္႔ကသု ေ ဆာင္ရြကပါ။ ဤကသစၥ င ပတ္သက္၍ မ ိနန ေ သာအြ်ကအလကမ်ားရရ သရန ကုန္က်စရသတ္ ေ ပးရန္မလုိဘဲ မိမိဘာသာစကား ဖင အကူအညီရယူ သ ႏိုင္ ။ 1-800-777-4890။

Hmong

Tsab ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb. Tsab ntawv tshaj xo no muaj cov ntsiab lus tseem ceeb txog koj daim ntawv thov kev pab los yog koj qhov kev pab cuam los ntawm CommunityCare. Saib cov caij nyoog los yog tej hnub tseem ceeb uas sau rau hauv daim ntawv no kom zoo. Tej zaum koj kuj yuav tau ua qee yam uas peb kom koj ua tsis pub dhau cov caij nyoog uas teev tseg rau hauv daim ntawv no mas koj thiaj yuav tau txais kev pab cuam kho mob los yog kev pab them tej nqi kho mob ntawd. Koj muaj cai kom lawv muab cov ntshiab lus no uas tau muab sau ua koj hom lus pub dawb rau koj. Hu rau 1-800-777-4890.

Tagalog

Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng CommunityCare. Tingnan ang mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa 1-800-777-4890.

French

Cet avis a d'importantes informations. Cet avis a d'importantes informations sur votre demande ou la couverture par l'intermédiaire de CommunityCare. Rechercher les dates clés dans le présent avis. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez 1-800-777-4890.

Laotian:

ການແຈ້ງການນ ້ີມ ຂໍ້ມູນສໍາຄັນ. ການແຈ້ງການນ ້ີມ
ຂໍ້ມູນທ ່ີສໍາຄັນກ່ຽວກັບຄໍາຮ້ອງສະໝັກຫ ຼືການຄ ຸ້ມຄອງຂອງທ່ານໂດຍຜ່ານ
CommunityCare. ເບິ່ງສໍາລັບກໍານົດວັນທ ່ີສໍາຄັນໃນແຈ້ງການນ ້ີ.
ທ່ານອາດຈໍາເປັນຕ້ອງໃຊ້ເວລາດໍາເນ ນການໂດຍກໍານົດເວລາທ ່ີແນ່ນອນ
ຈະຮັກສາການຄ ຸ້ມຄອງສ ຂະພາບຂອງທ່ານຫ ຼືການຊ່ວຍເຫ ຼືອທ ່ີມ
ຄ່າໃຊ້ຈ່າຍ. ທ່ານມ
ສິດທ ່ີຈະໄດ້ຮັບຂໍ້ມູນຂ່າວສານນ ້ີແລະການຊ່ວຍເຫ ຼືອໃນພາສາຂອງທ່ານທ ່ີ
ບໍ່ມ ຄ່າໃຊ້ຈ່າຍ. ໂທ 1-800-777-4890.

Thai:

ประกาศนี้มีข้อมูลสาคัญ
ประกาศนี้มีข้อมูลที่สาคัญเกี่ยวกับการการสมัครหรือขอบเขตประกันสุขภาพของคุณผ่าน
CommunityCare ดูกาหนดการในประกาศนี้
คุณอาจจะต้องดาเนินการภายในกาหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่าย
คุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือนี้ในภาษาของคุณโดยไม่มีค่าใช้จ่าย โทร1-800-777-4890.

Urdu

اس اشتہار میں اہم معالومات ہے۔ اس اشتہار میں CommunityCare سے اپ کے درخواست اور خدمات کے بارے میں اہم معالومات ہے۔ اشتہار میں اہم تاریخوں کا نظر کریں۔ ہو سکتا ہے کی صحت کی خدمات کو برقرار رکھنے اور اخراجات کی ادائگی میں مالی مدد ملنے کے لیے، اپ کو خاص تاریخ یا ڈیڈ لائن سے پہلے کچھ کارروائی کرنی پڑے گی۔ اپ کو اپنی زبان میں مفت مدد اور معالومات حاصل کرنے کا حق ہے۔
1-800-777-4890 فون کریں۔

Cherokee:

ᎤᏪᏅᏏᏗ ᏕᏕᏃᏣᏢᎢ ᎤᏐᏨᏅᏗ. ᎯᎠ ᎤᏪᏅᏏᏗ ᎡᏣᏃᎯᏎ ᏥᏣᏔᏂᏝᎢ ᎡᏣᏠᏨᏅᏁᏗ ᎤᏂᏅᎪᏔᏅ ᎯᏰᏂᏁᏉ ᎡᏣᏕᏎᏅᏅᏛᏱ CommunityCare ᏕᏣᏄᏫᏅᏓᏗᏈᎢ. ᏣᏕᎡᏅᏕᏅᏗ ᏓᏁᏓᏡᎡ ᎯᎠ ᏕᏕᏃᏣᏢᎢ. ᎡᎷᏇ ᎪᎱᏅᏗ ᏦᏭᏣᏗ ᎠᏰ ᏣᏰᏛᏍᏆ ᏱᏂᎬᏔᏅᏓ ᎤᏅᎠᏴ ᎢᏍ ᏥᏕᎠᏭᏄ. ᏁᎯ ᏣᏕᏘ ᎠᏂᎠᏡᏱᏅᏕ ᏣᏉ ᎠᏰ ᏧᎬᏩᏔᏅᎢ ᏢᎡ ᎤᏁᏟᏴᏅᏗ ᏂᏢᎡᎾ ᏳᏰᏔᏗ. ᎠᏓᏅᎪᏔᏅᏛ ᎠᏓᏅᏕᏔᏗ ᎡᏣᏁᏗ ᏃᏰ ᎡᏣᏃᎯᏎᏘ ᏣᏕᏢᏅᎬ ᏣᏕᏔᏂᎯᏅᏗᏱ ᏣᏤᏢ ᏕᏫᏂᎯᏅᏗ ᎬᏘ ᏃᏰ ᏧᎬᏩᏗ ᏂᏢᎡᎾ ᏢᎡᎢ. ᏗᏔᏃᏑᏗ ᏗᏎᏅᏗ ᎯᎠ 1-800-777-4890.

Persian-Farsi

این اعلامیه حامی اطلاعات مهم میباشد. این اعلامیه حامی اطلاعات مهم درباره فرم تقاضا و یا پوشش بیمه ای شما مربوط به CommunityCare به تاریخ های مهم در این اعلامیه توجه نمایید. شما ممکن است تا به تاریخ های مشخصی برای حقظ پوشش مزایای یا برای کمک به مخارج مزایای ملزوم به انجام کارهایی باشید. شما حق این را دارید که این اطلاعات و کمک را به زبان خود به طور رایگان دریافت نمایید 1-800-777-4890.

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