

**Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services**


**Coverage for:** Individual and/or Family | **Plan Type:** HMO



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, <http://www.fhcp.com/documents/small-group-2018>. 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.fhcp.com](http://www.fhcp.com) or call 1-877-615-4022 to request a copy.

| Important Questions   | Answers  | Why This Matters:   |
|---|--|---|
| What is the overall <a href="#">deductible</a> ?                                | <a href="#">Network providers</a> : \$1,000 Individual/<br>\$2,000 Family<br><a href="#">Out-of-network providers</a> : Not covered  | Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .  |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. <a href="#">Preventive care</a> and prescription drug coverage  | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply.   |
| 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> ? | <a href="#">Network providers</a> : \$4,000 Individual/<br>\$8,000 Family<br><a href="#">Out-of-network providers</a> : Not covered  | 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-billing</a> charges, prescription drug coverage 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.fhcp.com/find-providers/physician">www.fhcp.com/find-providers/physician</a> or call 1-877-615-4022 for a list of <a href="#">network providers</a> . | This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">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 provider's 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> ?    | Yes.   | This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</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<br>(You will pay the least)                               | Out-of-Network Provider<br>(You will pay the most) |   |
| <b>If you visit a health care <u>provider's</u> office or clinic</b> | Primary care visit to treat an injury or illness  | \$30 <u>Copay</u> /Visit   | Not covered  | Additional <u>cost share</u> may apply for Allergy shots, Injections and Infusions.   |
|  | <u>Specialist</u> visit   | \$50 <u>Copay</u> /Visit   | Not covered  | Additional <u>cost share</u> may apply for Allergy shots, Injections and Infusions.   |
|  | <u>Preventive care</u><br>Well Baby/Child Health/Annual Adult Physical Health Screening | \$30 Copay – PCP   | Not covered  | Preventive Colonoscopy (age 50+) 1 every 10 years. High Risk Colonoscopy 1 every 2 years. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. |
|  | Well Women's Assessment   | \$30 Copay – PCP<br>\$50 Copay – Specialist                                |  |   |
| Mammography/Bone Density <u>Screening</u>                            | No charge   |  |  |   |
| <b>If you have a test</b>  | <u>Diagnostic test</u> (x-ray, blood work)  | Lab work: No charge / X-ray:<br><u>Deductible</u> + 30% <u>Coinsurance</u> | Not covered  | Cost sharing varies based on type of diagnostic test performed. Tests in hospitals, or facilities owned and operated by hospitals, may have higher cost share.  |
|  | Imaging (CT/PET scans, MRIs)  | <u>Deductible</u> + 30% <u>Coinsurance</u>                                 | Not covered  | Prior approval required. Your benefits / services may be denied. Tests in hospitals, or facilities owned and operated by hospitals, may have higher cost share.   |

For more information about limitations and exceptions, see the plan or policy document at [www.fhcp.com/documents/small-group-2018](http://www.fhcp.com/documents/small-group-2018).

| Common Medical Event  | Services You May Need                            | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information   |
|---|--|--|--|--|
|   |  | Network Provider<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most) |  |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="http://www.fhcp.com/commercial-formulary">prescription drug coverage</a> is available at <a href="http://www.fhcp.com/commercial-formulary">http://www.fhcp.com/commercial-formulary</a> | Generic drugs                                    | Retail: \$3 <u>Copay</u> per <u>prescription</u> for Preferred at FHCP / Mail Order: \$6 <u>Copay</u> per <u>prescription</u> for Preferred / Retail: \$10 <u>Copay</u> per <u>prescription</u> for Non-Preferred at FHCP / Mail Order: \$27 <u>Copay</u> per <u>prescription</u> for Non-Preferred / Retail: \$15 <u>Copay</u> per <u>prescription</u> at Walgreen's. | Not covered  | Covers up to 31 day supply at retail pharmacy, and up to 93 day supply for mail order.   |
|   | Preferred brand drugs                            | Retail: \$30 <u>Copay</u> per <u>prescription</u> at FHCP / Mail Order: \$87 <u>Copay</u> per <u>prescription</u> / Retail: \$35 <u>Copay</u> per <u>prescription</u> at Walgreen's.   | Not covered  | Covers up to 31 day supply at retail pharmacy, and up to 93 day supply for mail order.   |
|   | Non-preferred brand drugs                        | Retail: \$55 <u>Copay</u> per <u>prescription</u> at FHCP / Mail Order: \$162 <u>Copay</u> per <u>prescription</u> / Retail: \$60 <u>Copay</u> per <u>prescription</u> at Walgreen's.  | Not covered  | Covers up to 31 day supply at retail pharmacy, and up to 93 day supply for mail order.   |
|   | <a href="#">Specialty drugs</a>                  | Retail: \$100 <u>Copay</u>   | Not covered  | Available at FHCP pharmacies only.   |
| <b>If you have outpatient surgery</b>   | Facility fee (e.g., ambulatory surgery center)   | <u>Deductible</u> + 30% <u>Coinsurance</u>   | Not covered  | Pre-certification/pre-authorization of coverage required for non-emergency outpatient surgical care. Your benefits / services may be denied. |
|   | Physician/surgeon fees                           | <u>Deductible</u> + 30% <u>Coinsurance</u>   | Not covered  | Prior approval required. Your benefits / services may be denied.   |
| <b>If you need immediate medical attention</b>  | <a href="#">Emergency room care</a>              | <u>Deductible</u> + 30% <u>Coinsurance</u>   | <u>Deductible</u> + 30% <u>Coinsurance</u>         | Waived if admitted.  |
|   | <a href="#">Emergency medical transportation</a> | <u>Deductible</u> + 30% <u>Coinsurance</u>   | <u>Deductible</u> + 30% <u>Coinsurance</u>         | —————none—————   |
|   | <a href="#">Urgent care</a>                      | <u>Deductible</u> + 30% <u>Coinsurance</u>   | <u>Deductible</u> + 30% <u>Coinsurance</u>         | —————none—————   |
| <b>If you have a hospital</b>   | Facility fee (e.g., hospital room)               | <u>Deductible</u> + 30% <u>Coinsurance</u>   | Not covered  | Pre-certification/pre-authorization of   |

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| Common Medical Event   | Services You May Need                     | What You Will Pay                            |  | Limitations, Exceptions, & Other Important Information   |
|--|---|--|--|--|
|  |   | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |  |
| <b>stay</b>  |   |  |  | coverage required for non-emergency admissions. Your benefits / services may be denied.  |
|  | Physician/surgeon fees                    | <u>Deductible</u> + 30% <u>Coinsurance</u>   | Not covered  | —————none—————   |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | \$50 <u>Copay</u> /Visit                     | Not covered  | —————none—————   |
|  | Inpatient services                        | <u>Deductible</u> + 30% <u>Coinsurance</u>   | Not covered  | Pre-certification/pre-authorization of coverage required for non-emergency admissions. Your benefits / services may be denied.   |
| <b>If you are pregnant</b>   | Office visits                             | \$50 <u>Copay</u> /Visit                     | Not covered  | Pre-certification/pre-authorization of coverage required for non-emergency admissions. Your benefits / services may be denied. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
|  | Childbirth/delivery professional services | <u>Deductible</u> + 30% <u>Coinsurance</u>   | Not covered  | Pre-certification/pre-authorization of coverage required for non-emergency admissions. Your benefits / services may be denied.   |
|  | Childbirth/delivery facility services     | <u>Deductible</u> + 30% <u>Coinsurance</u>   | Not covered  | Pre-certification/pre-authorization of coverage required for non-emergency admissions. Your benefits / services may be denied.   |
| <b>If you need help recovering or have other special health needs</b>            | <a href="#">Home health care</a>          | <u>Deductible</u> + 30% <u>Coinsurance</u>   | Not covered  | Prior approval required. Your benefits / services may be denied. Prior approval required. Coverage limited to 60 visits.   |
|  | <a href="#">Rehabilitation services</a>   | <u>Deductible</u> + 30% <u>Coinsurance</u>   | Not covered  | Coverage limited to 20 visits. Includes Physical, Speech, Occupational Therapy   |
|  | <a href="#">Habilitation services</a>     | Not covered                                  | Not covered  |  |
|  | <a href="#">Skilled nursing care</a>      | <u>Deductible</u> + 30% <u>Coinsurance</u>   | Not covered  | Pre-certification/pre-authorization of coverage required. Your benefits / services may be denied. Coverage   |

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| Common Medical Event                          | Services You May Need                     | What You Will Pay                            |  | Limitations, Exceptions, & Other Important Information   |
|---|---|--|--|--|
|   |   | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |  |
|   |   |  |  | limited to 20 days.  |
|   | <a href="#">Durable medical equipment</a> | Deductible + 30% Coinsurance                 | Not covered  | Prior approval required. Your benefits / services may be denied. Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age. |
|   | <a href="#">Hospice services</a>          | Deductible + 30% Coinsurance                 | Not covered  | —————none—————   |
| <b>If your child needs dental or eye care</b> | Children's eye exam                       | Not covered                                  | Not covered  |  |
|   | Children's glasses                        | Not covered                                  | Not covered  |  |
|   | Children's dental check-up                | Not covered                                  | Not covered  |  |

### Excluded Services & Other Covered Services:

| Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)               |  |  |
|--|--|--|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric surgery</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• Dental care (Child)</li> </ul> | <ul style="list-style-type: none"> <li>• Habilitation services</li> <li>• Hearing aids</li> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine eye care (Child)</li> <li>• Routine eye care (Adult)</li> <li>• Routine foot care unless for treatment of diabetes</li> <li>• Weight loss programs</li> </ul> |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)   |  |  |
| <ul style="list-style-type: none"> <li>• Chiropractic care</li> </ul>  |  |  |

**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: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). 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 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 the insurer at 1-877-615-4022. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). For group health coverage subject to ERISA contact your employee services

For more information about limitations and exceptions, see the plan or policy document at [www.fhcp.com/documents/small-group-2018](http://www.fhcp.com/documents/small-group-2018).

department. For non-federal governmental group health [plans](#) and church [plans](#) that are group health [plans](#) contact your employee services department. You may also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your [appeal](#). Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or [www.dol.gov/ebsa/consumer\\_info\\_health.html](http://www.dol.gov/ebsa/consumer_info_health.html).

**Does this [plan](#) provide [Minimum Essential Coverage](#)? Yes**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this [plan](#) meet [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 1-877-615-4022.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-615-4022.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-877-615-4022.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-615-4022.

————— *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 <u>deductible</u>   | \$1000 |
| ■ <u>Specialist coinsurance</u>          | \$50   |
| ■ <u>Hospital (facility) coinsurance</u> | 30%    |
| ■ <u>Other coinsurance</u>               | 30%    |

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>\$12,800</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$380          |
| <u>Copayments</u>                 | \$880          |
| <u>Coinsurance</u>                | \$2,740        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$4,060</b> |

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|  |        |
|--|--------|
| ■ The plan's overall <u>deductible</u>   | \$1000 |
| ■ <u>Specialist copayment</u>            | \$50   |
| ■ <u>Hospital (facility) coinsurance</u> | 30%    |
| ■ <u>Other coinsurance</u>               | 30%    |

This EXAMPLE event includes services like:

Primary care office visits (*including disease education*)  
Diagnostic tests (*blood work*)  
Prescription drugs  
Durable medical equipment (*glucose meter*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$7,400</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$0            |
| <u>Copayments</u>                 | \$1,500        |
| <u>Coinsurance</u>                | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Joe would pay is</b> | <b>\$1,560</b> |

### Mia's Simple Fracture

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

|  |        |
|--|--------|
| ■ The plan's overall <u>deductible</u>   | \$1000 |
| ■ <u>Specialist coinsurance</u>          | \$50   |
| ■ <u>Hospital (facility) coinsurance</u> | 30%    |
| ■ <u>Other coinsurance</u>               | 30%    |

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>\$1,900</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$1,000        |
| <u>Copayments</u>                 | \$150          |
| <u>Coinsurance</u>                | \$490          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,640</b> |

The plan would be responsible for the other costs of these EXAMPLE covered services.



## Discrimination is Against the Law

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

Florida Health Care Plans:

- 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 Daria Siciliano, RN-BC, CCM.

If you believe that Florida Health Care Plans 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: Daria Siciliano, RN-BC, CCM, Manager of Member Services, 1340 Ridgewood Avenue, Holly Hill, FL 32117. 1-844-219-6137, TTY: TRS Relay 711, 386-676-7149, [rights@fhcp.com](mailto:rights@fhcp.com).

You can file grievance in person or by mail, fax, or email. If you need help filing a grievance, Daria Siciliano, RN-BC, CCM Manager of Member Services 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>.



If you or someone you're helping has questions about **Florida Health Care Plans**, you have the right to get help and information in your language at no cost. To talk to an interpreter, call **1-877-615-4022. (TTY: TRS Relay 711)**

Si usted o alguien a quien ayuda tienen preguntas sobre **Florida Health Care Plans**, tienen derecho a obtener ayuda e información en su idioma de manera gratuita. Para hablar con un intérprete, llame al **1-877-615-4022. (TTY: TRS Relay 711)**

Si ou menm, oswa yon moun w ap ede, gen kesyon sou **Florida Health Care Plans**, ou gen dwa pou jwenn enfòmasyon nan lang ou gratis. Pou ale ak yon entèprèt, rele **1-877-615-4022. (TTY: TRS Relay 711)**

Nếu quý vị, hoặc người nào đó mà quý vị đang giúp đỡ, có các thắc mắc về **Florida Health Care Plans**, quý vị có quyền được nhận trợ giúp và thông tin bằng ngôn ngữ của quý vị miễn phí. Để trao đổi với phiên dịch, hãy gọi theo số **1-877-615-4022. (TTY: TRS Relay 711)**

Se você, ou alguém que estiver a ajudar, tiver dúvidas sobre **Florida Health Care Plans**, tem o direito de obter ajuda e informações na sua língua, sem nenhuma custo. Para falar com um intérprete, ligue para **1-877-615-4022. (TTY: TRS Relay 711)**

如果您或您正協助的某人對**Florida Health Care Plans**有疑問，您有權免費以您的語言取得本協助及資訊。如欲與口譯員交談，請致電**1-877-615-4022. (TTY: TRS Relay 711)**

Si vous ou une personne que vous aidez avez des questions au sujet de **Florida Health Care Plans**, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, veuillez appeler le **1-877-615-4022. (TTY: TRS Relay 711)**

Kung ikaw, o ang isang taong tinutulungan mo, ay may mga tanong tungkol sa **Florida Health Care Plans**, mayroon kang karapatang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang interpreter, tumawag sa **1-877-615-4022. (TTY: TRS Relay 711)**

Если у Вас или у кого-то, кому Вы помогаете, есть вопросы о программе **Florida Health Care Plans**, Вы имеет право бесплатно получить ответы в переводе на Ваш язык. Для того чтобы воспользоваться помощью устного переводчика, позвоните по телефону **1-877-615-4022. (TTY: TRS Relay 711)**

إذا كان لديك أو الشخص الذي تساعد استفسارات حول **Florida Health Care Plans**، يحق لك تلقي المساعدة والمعلومات بلغتك مجاناً. تحدث إلى مترجم فوري، اتصل على الرقم **1-877-615-4022. (TTY: TRS Relay 711)**

se voi, o una persona che state aiutando, avete domande relative al **Florida Health Care Plans**, avete diritto a ottenere assistenza e informazioni gratuitamente nella vostra lingua. Per parlare con un interprete, chiamare il numero **1-877-615-4022. (TTY: TRS Relay 711)**

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Falls Sie oder jemand, dem Sie helfen, irgendwelche Fragen über **Florida Health Care Plans** haben, so haben Sie Anspruch auf kostenlose Unterstützung und Informationen in Ihrer eigenen Sprache. Bitte rufen Sie uns unter der Nummer **1-877-615-4022. (TTY: TRS Relay 711)** an, um mit einem Dolmetscher/einer Dolmetscherin zu sprechen.

귀하 또는 귀하가 도와드리고 있는 분이 **Florida Health Care Plans**에 관한 질문이 있을 경우, 귀하에게는 무료로 본인이 구사하는 언어로 도움과 정보를 받을 권리가 있습니다. 통역으로 전화 연결되려면 **1-877-615-4022. (TTY: TRS Relay 711)** 번으로 전화해 주십시오.

Jeśli Ty lub ktoś, komu pomagasz macie pytania dotyczące **Florida Health Care Plans**, macie prawo uzyskać pomoc i informacje w swoim języku, bez żadnych kosztów. Porozmawiaj z tłumaczem, zadzwoń pod numer **1-877-615-4022. (TTY: TRS Relay 711)**

જો તમને અથવા તમે જેને મદદ કરી રહ્યાં છો તેમને **Florida Health Care Plans** વિશે કોઈ પ્રશ્નો હોય, તો તમને તમારી ભાષામાં કોઈ પણ ખર્ચ વિના મદદ અને માહિતી મેળવવાનો હક છે. દુભાષિયા સાથે વાત કરવા માટે **1-877-615-4022. (TTY: TRS Relay 711)** પર ફોન કરો.

หากคุณ หรือคนที่คุณกำลังช่วยเหลืออยู่มีคำถามเกี่ยวกับ **Florida Health Care Plans** คุณจะได้รับการช่วยเหลือและได้รับข้อมูลในภาษาของคุณโดยที่ไม่มีค่าใช้จ่ายใดๆ หากต้องการพูดคุยกับล่ามแปลภาษา โทร. **1-877-615-4022. (TTY: TRS Relay 711)**