Optima Vantage 20/40
10101VA002900200
Jefferson Science Associates/SURA – Group # 2704
Jefferson Science Associates/SURA Retirees – Group # 3300
Effective Date: 04/01/2021
Optima Health Plan
Large Group Benefit Summary

This benefit summary is not a contract or health plan policy from Optima Health. If there are any differences between this benefit summary and the Optima Health coverage documents issued when You are enrolled, the provisions of the coverage documents will prevail for all benefits, conditions, cost sharing, and limitations and exclusions.

This Benefit Summary is an overview of Your Covered Services and Your out-of-pocket cost sharing amounts including any Deductibles, Copayment and Coinsurance. You or Your means the Subscriber and each family member who is a Covered Person under the Plan. Details about Covered Services are in the section "What is Covered." Details about services and treatments that are not covered are in the section "What is Not Covered."

Some benefits require Pre-Authorization before You receive them. These services are marked with an * in the Benefit Summary.

Some Covered Services may have visit limits. Once a visit limit is reached, no additional services are covered under the benefit. If a service is shown as covered under Out-of-Network benefits visit limits are combined with In-Network and Out-of-Network benefits unless otherwise stated.

Services or treatment You receive Out-of-Network or from Non-Plan Providers will not be covered under Your Plan unless:

1. The Covered Service is an Emergency Service;
2. During treatment at an In-Network hospital or other In-Network facility You receive Covered Services from a Non-Plan Provider; or
3. We have approved Your Covered Service in advance as an Authorized Out-of-Network Service.

If Your Plan has a Deductible that is the dollar amount that must be paid out-of-pocket by a Member for Covered Services each year before the Plan begins to pay for benefits.

Copayments and Coinsurances listed in this Benefit Summary are amounts You pay directly to a Provider for a Covered Service. Copayments are shown as flat dollar amounts. Coinsurance is shown as a percentage of the Plan's Allowable Charge for Your Covered Service. You will pay a Copayment or a Coinsurance, but not both, for a Covered Service. For some benefits you may see the statement, "Cost sharing determined by the type and place of service." For these services Your cost sharing will be based on where you receive a service, for example in a physician office or inpatient setting, and/or the type of service.

Your Plan's Maximum Out-of-Pocket Amount means the total dollar amount Members pay, or that are paid on their behalf, out-of-pocket for most Covered Services during a year. Deductibles, Copayments and Coinsurance for most Covered Services count toward the maximum amount.

Effective Period: From 04/01/2021 through 03/31/2022		
Deductible and Maximum Out-of-Pocket Amount (MOOP)		
	In-Network	**Out-of-Network**
Deductible Calendar Year	Your Plan Does Not Have a Deductible	Not Covered
	In-Network	**Out-of-Network**
Maximum Out-of-Pocket Calendar Year	$2,500/Individual; $5,000/Family	Not Covered

Most amounts You pay, or that are paid on Your behalf, for In-Network Covered Services will count toward meeting the In-Network Maximum Out of Pocket Amount.
The following will not count toward the Plan maximum amount(s):

- Amounts You pay for services not covered under Your Plan;
- Amounts You pay for any services after a benefit limit has been reached;
- Balance billing amounts that are more than the Plan's Allowable Charge for a Covered Service from Non-Plan Providers;
- Premium amounts;
- Copayments, Coinsurance, or Deductibles for Covered Services that are not Essential Health Benefits;
- Ancillary charges which result from a request for a brand name outpatient prescription drug when a Generic Drug is available;
- Other services in this Benefit Summary that are shown as excluded from the maximum amount.

If You are the Subscriber, and the only Member covered under Your Plan, the Individual maximum applies. If You have other Family Members on Your Plan the Family maximum applies. Under Family coverage the Individual maximum applies separately to each covered Family Member. Once the total Family coverage maximum is met the Family maximum amount is satisfied. No one Member can contribute more than their Individual maximum amount to the Family limit.

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Benefit	In-Network	Out-of-Network
Physician Office Visits Your Copayment or Coinsurance applies to Covered Services done during an office visit. You will pay an additional Copayment or Coinsurance for outpatient therapies and services, injectable and infused medications, allergy care, testing and serum, outpatient advanced imaging procedures, and sleep studies done during an office visit. Virtual Consults must be provided by Optima Health approved providers. ***Pre-Authorization is required for in-office surgery.**		
Primary Care Visit	You Pay $20	Not Covered
Virtual Consult	You Pay $10	Not Covered
Specialist Visit	You Pay $40	Not Covered
Vaccines and Immunotherapeutic Agents You are responsible for Coinsurance amount up to a maximum of $250 per dose. This does not include routine immunizations covered under Preventive Care.	You Pay 50%	Not Covered
Preventive Care Recommended Preventive Care Services are covered at no cost sharing when received from In-Network Plan Providers. You may still have to pay an office visit Copayment or Coinsurance when You receive preventive care. Some services may be provided under Your prescription drug benefit. Please use the following link for a complete list of covered preventive care services: https://www.healthcare.gov/what-are-my-preventive-care-benefits/		
Recommended exams, screenings, tests, immunizations, and other services	No Charge	Not Covered
Outpatient Therapies and Services You Pay a Copayment or Coinsurance amount for each visit for services done in a Physician's office, a free-standing outpatient facility, a Hospital outpatient facility, or at home as part of Your Skilled Home Health Care Services benefit. Visit limits for physical, occupational, and speech therapy will not apply if You get that care as part of a treatment plan for Autism Spectrum Disorder.		
Occupational and Physical Therapy* Services limited to 30 combined visits per Calendar year.	**PCP Office Visit** You Pay $25 **Specialist Office Visit** You Pay $25 **Outpatient Facility** You Pay $25	Not Covered
Speech Therapy* Services limited to 30 visits per Calendar year.	**PCP Office Visit** You Pay $25 **Specialist Office Visit** You Pay $25 **Outpatient Facility** You Pay $25	Not Covered
Cardiac Rehabilitation* Services limited to 30 visits per Calendar year.	**PCP Office Visit** You Pay $25 **Specialist Office Visit** You Pay $25 **Outpatient Facility** You Pay $25	Not Covered

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Benefit	In-Network	Out-of-Network
Pulmonary Rehabilitation* Services limited to 30 visits per Plan year.	**PCP Office Visit** You Pay $25 **Specialist Office Visit** You Pay $25 **Outpatient Facility** You Pay $25	Not Covered
Vascular Rehabilitation* Services limited to 30 visits per Calendar year.	**PCP Office Visit** You Pay $25 **Specialist Office Visit** You Pay $25 **Outpatient Facility** You Pay $25	Not Covered
Vestibular Rehabilitation* Services limited to 30 visits per Calendar year.	**PCP Office Visit** You Pay $25 **Specialist Office Visit** You Pay $25 **Outpatient Facility** You Pay $25	Not Covered
IV Infusion Therapy	**PCP Office Visit** You Pay $20 **Specialist Office Visit** You Pay $40 **Outpatient Facility** You Pay $40	Not Covered
Respiratory/Inhalation Therapy	**PCP Office Visit** You Pay $20 **Specialist Office Visit** You Pay $40 **Outpatient Facility** You Pay $40	Not Covered
Chemotherapy and Chemotherapy Drugs*	**PCP Office Visit** You Pay $20 **Specialist Office Visit** You Pay $40 **Outpatient Facility** You Pay $40	Not Covered
Radiation Therapy*	**PCP Office Visit** You Pay $20 **Specialist Office Visit** You Pay $40 **Outpatient Facility** You Pay $40	Not Covered
Pre-Authorized Injectable and Infused Medications* Includes injectable and infused medications, biologics, and IV therapy medications that require Pre-Authorization. Office visit, outpatient facility, or home health Copayment or Coinsurance will also apply. Does not apply to Chemotherapy Drugs	You Pay 20%	Not Covered

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Benefit	In-Network	Out-of-Network
Outpatient Dialysis You Pay a Copayment or Coinsurance for each visit at any place of service. Coverage also includes home dialysis equipment and supplies.		
Dialysis Services	You Pay $40	Not Covered
Outpatient Surgery You pay a Copayment or Coinsurance for services provided in a free-standing ambulatory surgery center or Hospital outpatient surgical facility.		
Surgery Services*	You Pay $200	Not Covered
Outpatient Lab, Diagnostic, Imaging and Testing You pay a Copayment or Coinsurance for services done in a free-standing outpatient facility or lab or a Hospital outpatient facility or lab.		
Diagnostic Procedures	You Pay $40	Not Covered
X-Ray **Ultrasound** **Doppler Studies**	You Pay $40	Not Covered
Lab Work	You Pay $40	Not Covered
Outpatient Advanced Imaging, Testing and Scans You pay a Copayment or Coinsurance for services done in a Physician's office, a free-standing outpatient facility or a Hospital outpatient facility or lab.		
Magnetic Resonance Imaging (MRI)* **Magnetic Resonance Angiography (MRA)*** **Positron Emission Tomography (PET)*** **Computerized Axial Tomography (CT)*** **Computerized Axial Tomography Angiogram (CTA)*** **Magnetic Resonance Spectroscopy (MRS)** **Single Photon Emission Computed Tomography (SPECT)** **Nuclear Cardiology** **Sleep Studies***	You Pay $150	Not Covered
Maternity Care Includes prenatal care, delivery, and postpartum care and services, and home health visits. You must also pay Your Inpatient Hospital Copayment or Coinsurance. Recommended preventive care services and screenings are covered under preventive benefits.		
Maternity Care ***Pre-Authorization is required for prenatal services**	You Pay $450 Global Copayment for delivering Obstetrician prenatal, delivery, and postpartum services	Not Covered
Inpatient Services		
Inpatient Hospital Services*	You Pay $200 per day up to a $1,000 maximum Copayment per Admission	Not Covered
Transplants* Covered at contracted facilities only.	You Pay $200 per day up to a $1,000 maximum Copayment per Admission	Not Covered

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Benefit	In-Network	Out-of-Network
Skilled Nursing Facility Services* Limited to a maximum of 90 days per Calendar year.	No Charge	Not Covered
Ambulance Services Includes Emergency transportation, or non-Emergency transportation that is Medically Necessary and Pre-Authorized. You pay Copayment or Coinsurance per transport each way.		
Air, Water, Ground Services *Pre-Authorization is required for non-emergency transportation.	You Pay $100	Not Covered except for Emergency Services
Emergency Services Includes Emergency Services, Physician services, Advanced Diagnostic Imaging, such as MRIs and CT scans, other facility charges, such as diagnostic x-ray and lab services and medical supplies provided in an Emergency Department In-Network or Out-of-Network.		
Emergency Services	You Pay $200	You Pay $200
Urgent Care Services Includes Urgent Care Services, Physician services, and other ancillary services received at an Urgent Care facility. If You are transferred to an Emergency Department from an Urgent Care Center, You will pay the Emergency Services Copayment or Coinsurance.		
Urgent Care Services	You Pay $40	Not Covered
Mental Health and Substance Use Disorder Services Includes inpatient and outpatient services for the treatment of mental health and substance use disorders. ***Pre-Authorization is required for Inpatient Services, partial hospitalization services, intensive outpatient program (IOP) services, Transcranial Magnetic Stimulation (TMS), and electro-convulsive therapy.** Virtual Consults must be furnished by approved Optima Health providers.		
Inpatient Services*	You Pay $200 per day up to a $1,000 maximum Copayment per Admission	Not Covered
Outpatient Office Visits	You Pay $20	Not Covered
Virtual Consults	You Pay $10	Not Covered
Other Outpatient Visits (Facility/Freestanding Centers)	You Pay $20	Not Covered
Employee Assistance Visits Services include short-term problem assessment by licensed behavioral health providers, and referral services for employees, and other covered family members and household members. To use services call 757-363-6777 or 1-800-899-8174	No Charge for up to 5 visits from Optima Health Employee Assistance providers per presenting issue as determined by treatment protocols.	
Diabetes Treatment Includes supplies, equipment, and education. An annual diabetic eye exam is covered from an In-Network Plan Provider or a participating EyeMed Vision Services provider at the office visit Copayment or Coinsurance amount.		
Insulin Pumps*	No Charge	Not Covered
Pump Infusion Sets and Supplies*	You Pay 20%	Not Covered

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Benefit	In-Network	Out-of-Network
Testing Supplies Includes test strips, lancets, lancet devices, blood glucose monitors and control solution. ***Pre-Authorization is required for talking blood glucose monitors**	Covered under the Plan's Prescription Drug Benefit	Not Covered
Insulin, Needles, Syringes	Covered under the Plan's Prescription Drug Benefit	Not Covered
Outpatient Self-Management Training, Education, Nutritional Therapy	No Charge	Not Covered
Prosthetic Limb Replacement		
Prosthetic Devices and Components, repair, fitting, replacement, adjustment.*	You Pay 30%	Not Covered
Autism Spectrum Disorder Includes diagnosis and treatment of Autism Spectrum Disorder.		
Autism Spectrum Disorder*	Cost sharing determined by the type and place of service.	Not Covered
Durable Medical Equipment (DME) and Supplies		
DME, Orthopedic Devices, Prosthetic Appliances, Devices ***Pre-Authorization is required for items over $750** ***Pre-Authorization is required for repair, replacement and rental items.**	No Charge	Not Covered
Early Intervention Services For Dependent children from birth to age three.		
Speech and language therapy, Occupational therapy, Physical therapy, Assistive technology services and devices. *	Cost sharing determined by the type and place of service.	Not Covered
Home Health Care Includes skilled home health care services for home bound Members. You will also pay a separate Copayment or Coinsurance for therapies and infused medications received at home		
Home Health Care* Limited to a maximum of 100 visits per Calendar year.	You Pay $20	Not Covered
Hospice Care		
Hospice Care*	No Charge	Not Covered
Reconstructive Breast Surgery Includes Covered Services for Members who have had a mastectomy.		
Surgery and Reconstruction* **Prostheses*** **Physical Complications*** **Lymphedema***	Cost sharing is determined by the type and place of service.	Not Covered

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Benefit	In-Network	Out-of-Network
Infertility Services Includes limited services, for Members only, to diagnose and treat underlying medical conditions resulting in Infertility		
Endometrial biopsies Limited to 2 per lifetime **Semen analysis** Limited to 2 per lifetime **Hysterosalpingography** Limited to 2 per lifetime **Sims-Huhner test (smear)** Limited to 4 per lifetime **Diagnostic laparoscopy** Limited to 1 per lifetime	Cost sharing is determined by the type and place of service.	Not Covered
Clinical Trials Includes "routine patient costs" for a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition.		
Clinical Trial Services*	Cost sharing is determined by the type and place of service.	Not Covered
Allergy Care		
Allergy Care, Testing, and Serum	Cost sharing is determined by the type and place of service.	Not Covered
Telemedicine Services Includes the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Your out-of-pocket Deductible, Copayment, or Coinsurance amounts will not exceed the Deductible, Copayment or Coinsurance amount You would have paid if the same services were provided through face-to-face diagnosis, consultation, or treatment.		
Telemedicine Services	Cost sharing is determined by the type and place of service.	Not Covered
Out of Area Dependent Program Dependent Children who are Covered Persons and living outside of their Plan's Service Area will receive In-Network benefits when Covered Services are received from Optima Health providers that participate in the Out of Area Program. The Plan will require eligible out of area Dependents to complete an annual certification form prior to being eligible for the program. Except for Emergency Services any Covered Services received outside of the service area from Out of Network Non-Plan Providers that are not included in the Out of Area Dependent Program will not be covered.		
Out of Area Program Services *Pre-Authorization requirements apply depending on the type and place of service.	Cost sharing determined by the type and place of service	Not Covered

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Benefit	In-Network	Out-of-Network
Optional Benefit Vision Care and Materials Rider Optima Health contracts with EyeMed Vision Services to administer this benefit.		
Includes a routine eye examination, refraction, and materials including lenses and frames, or contact lenses once every 12 months from a Participating EyeMed Provider.	**Examinations** No Charge Contact lens examinations require the eye examination Copayment plus the difference between the contact lens examination cost and the eyeglass examination cost. **Materials** Lenses (single, vision, bifocal, trifocal) covered in full. Frames covered in full up to $100 retail. Contact lenses (in lieu of glasses) covered in full up to $100 retail. Cost sharing amounts You pay for Covered Services under this rider will not count toward Your Deductible or Maximum Out of Pocket Amount unless services are considered an Essential Health Benefit (EHB) for children.	Not Covered

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Prescription Drugs
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This Benefit Summary describes Your Plan's outpatient prescription drug coverage. All drugs must be United States Food, Drug Administration (FDA) approved, and you must have a prescription. You will need to pay Your Copayment or Coinsurance when you fill your prescription at the pharmacy. If Your Plan has a Deductible, You must meet that amount before your coverage begins. Some drugs require Pre-Authorization by Your Physician, and some quantities may be limited. Details about Covered Services are in the section "What is Covered". Details about services and treatments that are not covered are in the section "What is Not Covered."

Prescriptions may be filled at a Plan pharmacy or at a non-participating pharmacy if the non-participating pharmacy or its intermediary has agreed in writing to accept as payment in full reimbursement from the Plan, including any Copayment or Coinsurance consistently imposed by the plan, at the same level as the Plan gives to participating pharmacies.

Prescription drugs are placed into Tiers by the Plan's Pharmacy and Therapeutics Committee. For a single Copayment or Coinsurance charge You may receive up to a consecutive 31-day supply of a covered drug at a retail pharmacy or Optima's Specialty Pharmacy. Specialty Drugs will be delivered to Your home address from Our specialty mail order drug pharmacy.

Selected Generic Drugs (Tier 1) includes commonly prescribed Generic Drugs. Other drugs may be included in Tier 1 if the Plan recognizes they show documented long-term decreases in illness.

Selected Brand & Other Generic Drugs (Tier 2) includes brand-name drugs and some Generic Drugs with higher costs than Tier 1 Generic Drugs that are considered by the Plan to be standard therapy.

Non-Selected Brand Drugs (Tier 3) includes brand name drugs not included by the Plan on Tier 1 or Tier 2. These may include single source brand name drugs that do not have a Generic Product Level equivalent or a therapeutic equivalent. Drugs on this tier may be higher in cost than equivalent drugs, or drugs determined to be no more effective than equivalent drugs on lower tiers.

Specialty Drugs (Tier 4) includes those drugs classified by the Plan as Specialty Drugs. Tier 4 also includes compound prescription medications. Specialty Drugs have unique uses and are generally prescribed for people with complex or ongoing medical conditions. A compound prescription medication is used to meet the needs of a specific individual and must have at least one ingredient requiring a Physician's authorization by State or Federal Law.. Specialty Drugs include the following:

1. Medications that treat certain patient populations including those with rare diseases;
2. Medications that require close medical and pharmacy management and monitoring;
3. Medications that require special handling and/or storage;
4. Medications derived from biotechnology and/or blood derived drugs or small molecules;
5. Medications that can be delivered via injection, infusion, inhalation, or oral administration; and
6. Medications subject to restricted distribution by the U.S. Food and Drug Administration.

Specialty Drugs are only available through the Optima Health specialty mail order pharmacy. Proprium Pharmacy at 1-855-553-3568. Specialty Drugs will be delivered to Your home address. If You have a question or need to find out if Your drug is considered a Specialty Drug please call Pharmacy Member Services at the number on Your Optima Health ID Card. You can also log onto optimahealth.com for a list of Specialty Drugs.

Deductibles, Maximum Out of Pocket Amount (MOOP), and Benefits	
Deductibles	Your Plan Does Not Have a Deductible
Maximum Out-of-Pocket Amount	Outpatient Prescription Drug Deductibles, Copayments or Coinsurance apply to the Plan's Maximum Medical Out-of-Pocket Limit Ancillary charges which result from a request for a brand name outpatient prescription drug when a Generic Drug is available are not Covered, do not count toward the Plan's Maximum Out-of-Pocket Amount and must continue to be paid after the Maximum Out-of-Pocket Amount has been met.
Insulin, syringes, and needles	A Member's cost sharing payment for a covered insulin drug will not exceed $50 per 30-day supply per prescription, regardless of the amount or type of insulin needed to fill each prescription. You pay the cost sharing for the applicable Tier. Deductible does not apply.
Diabetic Testing Supplies covered including blood glucose monitors, test strips, lancets, lancet devices, and control solution	No Charge Members can pick up supplies at any network pharmacy. LifeScan products will be the preferred brand. However, the Plan reserves the right to change or add additional preferred brands. Pre-Authorization is required for talking blood glucose meters.
Formulary	This Plan has a closed formulary and covers a specific list of drugs and medications. If Your drug is not on Our formulary, We have a process in place to request coverage. Please use the following link to see a list of drugs on the Plan's formulary: https://www.optimahealth.com/documents/drug-lists/form-doc-drug-list-standard-formulary.pdf Certain prescription drugs will be covered at a Generic Product Level established by the Plan. If a Generic Product Level has been established for a drug and You or Your prescribing Physician requests the brand-name drug or a higher costing Generic Drug, You must pay the difference between the cost of the dispensed drug and the Generic Product Level in addition to the Copayment or Coinsurance charge.

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Copayment and Coinsurance Retail Pharmacy or Optima Specialty Pharmacy for up to a 31 day supply	
ACA Preventive Drugs ACA preventive prescription drugs and over the counter items identified as an A or B recommendation by the United States Preventive Services Task Force. Please use this link for a list of covered preventive care services: https://www.healthcare.gov/what-are-my-preventive-care-benefits/	No Charge. Deductible does not apply. Covered Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) are Limited to two 90 day courses of treatment per year when prescribed by a health care provider.
Selected Generic Drugs **Tier 1**	You Pay $10
Selected Brand & Other Generic Drugs **Tier 2**	You Pay $40
Non-Selected Brand Drugs **Tier 3**	You Pay $60
Specialty Drugs **Tier 4**	You Pay 20% up to a maximum Copayment of $250.

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Copayment and Coinsurance Mail Order (If Your Drug is available) for up to a 90 day supply Some Outpatient prescription drugs in Tier 1, Tier 2, and Tier 3 are available from the Plan's Mail Order Pharmacy OptumRx Home Delivery. You may call OptumRx Home Delivery at 1-866-244-9113 to find out if Your drug is available. Tier 4 Specialty Drugs are only available from the Plan's Specialty Pharmacy Proprium Pharmacy and are limited to a 31 day supply.	
ACA Preventive Drugs ACA preventive prescription drugs and over the counter items identified as an A or B recommendation by the United States Preventive Services Task Force. Please use this link for a list of covered preventive care services: https://www.healthcare.gov/what-are-my-preventive-care-benefits/	No Charge. Deductible does not apply. Covered Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) are Limited to two 90 day courses of treatment per year when prescribed by a health care provider.
Selected Generic Drugs **Tier 1**	You Pay $25
Selected Brand & Other Generic Drugs **Tier 2**	You Pay $100
Non-Selected Brand Drugs **Tier 3**	You Pay $180
Specialty Drugs **Tier 4**	You Pay 20% up to a maximum Copayment of $250.

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Notice/Notes/Terms & Conditions:

Dependent Children enrolled in the Plan are Covered until the end of month they turn 26.

This Plan does not have pre-existing condition exclusions.

This Plan does not have annual or lifetime dollar limits on Essential Health Benefits.

This is a group plan sponsored by Your employer. Your employer will pay the premium to us on Your behalf. Your employer will tell You how much You must contribute, if any, to the premium.

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Need help in another language? Call us.

需要以其他语言获得帮助？ 联系我们。

다른 언어로 도움이 필요하십니까? 저희에게 연락 해 주세요.

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Kailangan ng tulong sa ibang wika? Tawagan kami.

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Saad łahgo át'éhígíí daa ts'í bee shíká a'doowoł nínízin. Nihich'į' hólne'.

1-855-687-6260

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.