HealthSelect of Texas®

HealthSelect℠ Out-of-State Plan

Coverage for: Individual + Family | **Plan Type:** PPO

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 contribution[3]) 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 1-800-252-8039 or visit www.healthselectoftexas.com. 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.healthcare.gov/sbc-glossary/ or call 1-800-252-8039 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network $0 Individual / $0 Family Non-network[1] $500 Individual / $1,500 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 services in-network and network services are covered before you meet your deductible.	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 www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $50 for prescription drug expenses per person, and $5,000 for bariatric surgery for active employees	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. Note: The $50 prescription drug deductible does not apply to formulary insulin and certain diabetic supplies.
What is the out-of-pocket limit for this plan?	Network[2]: $8,300 Individual / $16,600 Family (beginning Jan. 1, 2026) Non-network[1]: No Limit Coinsurance Limit: $2,000 Network /$7,000 Non-network[1] per individual	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?	Contributions[3], balance-billing[4] charges, services this plan doesn't cover, and bariatric surgery benefits.	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.healthselectoftexas.com or call 1-800-252-8039 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 a non-network[1] 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)[4]. Be aware, your network provider might use a non-network[1] provider for some services (such as lab work). Check with your provider before you get services.

Do you need a referral to see a specialist?	No, referrals are not required to see a specialist.	You can see the specialist you choose without a referral.

1 Under this plan, out-of-network is considered non-network.
2 Out-of-pocket limits under this plan reset each calendar year. The network out-of-pocket limit that applies to this plan from 9/1/2025 through 12/31/2025 is $8,050 per Individual and $16,100 per Family.
3 Under this plan, payment for your health plan coverage is considered a contribution rather than a premium.
4 Non-network[1] providers may not balance bill you for certain services. Refer to the Master Benefit Plan Document (MBPD) for details.

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 (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	$25 copayment/visit	40% coinsurance	None
	Specialist visit	$40 copayment/visit	40% coinsurance	None
	Preventive care/screening/ Immunization	No charge	40% coinsurance	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, etc.)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	$100 copayment/visit plus 20% coinsurance	$100 copayment/visit plus 40% coinsurance	None

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.healthselectrx.com	Generic drugs (Tier 1)	$10 copayment (non-maintenance) (30-day supply), $10 copayment (maintenance) (30-day supply); $30 copayment (mail order or extended days' supply) (90-day supply)	$10 copayment plus 40% coinsurance (non-maintenance) (30-day supply), $10 copayment plus 40% coinsurance (maintenance) (30-day supply); $30 copayment plus 40% coinsurance (mail order or extended days' supply) (90-day supply)	Preauthorization may be required. Failure to obtain preauthorization may increase your cost. Note: If a generic drug is available and you choose to buy the preferred or non-preferred brand drug, you will pay the generic copayment plus the cost difference between the preferred or non-preferred brand drug and the generic drug. Note: Outpatient formulary insulin, regardless of tier, has a maximum $25 copayment per 30-day supply.
	Preferred brand drugs (Tier 2)	$35 copayment (non-maintenance) (30-day supply), $45 copayment (maintenance) (30-day supply); $105 copayment (mail order or extended days' supply) (90-day supply)	$35 copayment plus 40% coinsurance (non-maintenance) (30-day supply), $45 copayment plus 40% coinsurance (maintenance) (30-day supply); $105 copayment plus 40% coinsurance (mail order or extended days' supply) (90-day supply)	
	Non-preferred brand drugs (Tier 3)	$60 copayment (non-maintenance) (30-day supply), $75 copayment (maintenance) (30-day supply); $180 copayment (mail order or extended days' supply) (90-day supply)	$60 copayment plus 40% coinsurance (non-maintenance) (30-day supply), $75 copayment plus 40% coinsurance (maintenance) (30-day supply); $180 copayment plus 40% coinsurance (mail order or extended days' supply) (90-day supply)	

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)	
	Specialty drugs	If purchased through a pharmacy, specialty drugs are covered as preferred brand drugs or non-preferred brand drugs as listed above. Otherwise, covered as a medical benefit.	If purchased through a pharmacy, specialty drugs are covered as preferred brand drugs or non-preferred brand drugs as listed above. Otherwise, covered as a medical benefit.	Preauthorization may be required. Failure to obtain preauthorization may increase your cost. Note: If a generic drug is available and you choose to buy the preferred or non-preferred brand drug, you will pay the generic copayment plus the cost difference between the preferred or non-preferred brand drug and the generic drug.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copayment/visit plus 20% coinsurance	$100 copayment/visit plus 40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$150 copayment/visit plus 20% coinsurance	$150 copayment/visit plus 20% coinsurance	Non-network[1] deductible does not apply. Emergency room copayment waived if admitted. See the plan document for non-emergent benefit information.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Non-network[1] deductible does not apply.
	Urgent care	$50 copayment/visit plus 20% coinsurance	$50 copayment/visit plus 20% coinsurance	Non-network[1] deductible does not apply. See the plan document for non-emergent benefit information.
If you have a hospital stay	Facility fee (e.g., hospital room)	$150/day copayment per admission plus 20% coinsurance	$150/day copayment per admission plus 40% coinsurance	$750 copayment max per admission. $2,250 inpatient copayment max per calendar year per person.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copayment for office visits and 20% coinsurance for other outpatient services	40% coinsurance	None
	Inpatient services	$150/day copayment per admission plus 20% coinsurance	$150/day copayment per admission plus 40% coinsurance	$750 copayment max per admission. $2,250 inpatient copayment max per calendar year per person. None

* For more information about limitations, exceptions, & other important information, see the plan or policy document at www.healthselect.bcbstx.com/medical-benefits.

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 are pregnant	Office visits	$25 copayment for primary care provider/$40 copayment for specialist for initial office visit to confirm pregnancy No Charge after initial visit for routine maternity care	40% coinsurance	Depending on the type of service, a copayment, coinsurance, or deductible may apply for non-routine maternity care. Non-routine maternity care includes things like ultrasound, amniocentesis, special screening tests for genetic disorders, etc.
	Childbirth/delivery professional services	No Charge	40% coinsurance	Benefits to treat any related complications of pregnancy will be paid at the same level as benefits for any other condition, sickness, or Injury.
	Childbirth/delivery facility services	$150/day copayment per admission plus 20% coinsurance	$150/day copayment per admission plus 40% coinsurance	$750 copayment max per admission. $2,250 inpatient copayment max per calendar year per person.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Max of 100 non-network[1] visits per calendar year per person. Non-network[1] home infusion therapy is not covered.
	Rehabilitation services	20% coinsurance	40% coinsurance	None
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	None
	Durable medical equipment	20% coinsurance	40% coinsurance	Repair or replacement limit of one every 3 years per person unless change in condition or physical status.
	Hospice services	20% coinsurance	40% coinsurance	None

* For more information about limitations, exceptions, & other important information, see the plan or policy document at www.healthselect.bcbstx.com/medical-benefits.

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 your child needs dental or eye care	Children's eye exam	$40 copayment/visit	40% coinsurance	Limit of one routine exam per calendar year per person. No referral is required for eye exams. One preventive care visual acuity screening covered with no copayment at network provider.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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.)

- Acupuncture
- Cosmetic surgery
- Dental care
- Educational services, excluding Diabetes Self-Management Training Programs
- Glasses and Contact Lenses
- Infertility treatment
- Long-term care
- Personal comfort items
- Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery for active employees
- Chiropractic care
- Hearing aids (limited to $1,000 per ear per 36-month period). Eligible minors aged 18 and under are not subject to $1,000 hearing aid maximum.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (limited to 96 hours per year for non-network[1])
- Network diagnostic mammograms are covered at 100%
- Routine eye care
- Weight loss programs (Limited to certain programs. See Master Benefit Plan Document for details on covered programs)

* For more information about limitations, exceptions, & other important information, see the plan or policy document at www.healthselect.bcbstx.com/medical-benefits.

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: the HealthSelect of Texas plan at 1-800-892-2803, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or 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 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: Blue Cross and Blue Shield of Texas at 1-800-252-8039 or visit www.healthselectoftexas.com, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Texas Department of Insurance's Consumer Health Assistance Program at 1-800-252-3439 or visit www.texashealthoptions.com.

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? 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 1-800-252-8039.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-252-8039.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-252-8039.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-252-8039.

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 copayments	$40
Hospital (facility) coinsurance	20%
Hospital (facility) copayments	$150
Other coinsurance	20%

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**

In this example, Peg would pay:

Cost sharing	
Deductibles	$10
Copayments	$400
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,370**

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 copayments	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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**

In this example, Joe would pay:

Cost sharing	
Deductibles	$50
Copayments	$700
Coinsurance	$20
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$790**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayments	$40
Hospital (facility) coinsurance	20%
Hospital (ER) copayments	$150
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost sharing	
Deductibles	$10
Copayments	$400
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$810**

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

BlueCross BlueShield of Texas

Non-Discrimination Notice

Health Care Coverage Is Important For Everyone

We do not discriminate on the basis of race, color, national origin (including limited English knowledge and first language), age, disability, or sex (as understood in the applicable regulation). We provide people with disabilities with reasonable modifications and free communication aids to allow for effective communication with us. We also provide free language assistance services to people whose first language is not English.

To receive reasonable modifications, communication aids or language assistance free of charge, please call us at 800-252-8039.

If you believe we have failed to provide a service, or think we have discriminated in another way, you can file a grievance with:

Office of Civil Rights Coordinator
Attn: Office of Civil Rights Coordinator
300 E. Randolph St., 35th Floor
Chicago, IL 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: CivilRightsCoordinator@bcbsil.com

You can file a grievance by mail, fax or email. If you need help filing a grievance, please call the toll-free phone number listed on the back of your ID card (TTY: 711).

You may file a civil rights complaint with the US Department of Health and Human Services, Office for Civil Rights, at:

Centralized Case Management Operations
US Dept of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
Email: OCRComplaint@hhs.gov

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal:
ocrportal.hhs.gov/ocr/smartscreen/main.jsf
Complaint Forms:
hhs.gov/civil-rights/filing-a-complaint/index.html

This notice is available on our website at healthselect.bcbstx.com/important-info/non-discrimination-notice

ATTENTION: If you speak another language, 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 800-252-8039 (TTY: 711) or speak to your provider.

Español Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 800-252-8039 (TTY: 711) o hable con su proveedor.
Việt Vietnamese	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 800-252-8039 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

中文 Chinese	注意：如果您说中，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 800-252-8039（文本电话：711）或咨询您的服务提供商。
한국어 Korean	주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 800-252-8039 (TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.
العربية Arabic	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 800-252-8039 (TTY: 711) أو تحدث إلى مقدم الخدمة.
اردو Urdu	توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ 800-252-8039 (TTY: 711) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔
Tagalog Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 800-252-8039 (TTY: 711) o makipag-usap sa iyong provider.
Français French	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 800-252-8039 (TTY : 711) ou parlez à votre fournisseur.
हिंदी Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 800-252-8039 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।
فارسي Persian	توجه: اگر فارسی صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 800-252-8039 (تلەتایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 800-252-8039 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.
ગુજરાતી Gujarati	ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 800-252-8039 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.
РУССКИЙ Russian	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 800-252-8039 (TTY: 711) или обратитесь к своему поставщику услуг.
日本語 Japanese	注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。800-252-8039（TTY：711）までお電話ください。または、ご利用の事業者にご相談ください。
ລາວ Laotian	ຊືນຸຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 800-252-8039 (TTY: 711) ຫຼື ຄົນກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.
Diné Navajo	SHOOH: Diné bee yáníłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'į' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjį' 800-252-8039 (TTY: 711) hodíilnih doodago nika'análwo'í bich'į' hanidziih.