BlueCross BlueShield of Texas

Public Employee Benefit Cooperative

2027 Summary of Benefits

Blue Cross Group Medicare Advantage (HMO)SM

January 1, 2027 – December 31, 2027

This booklet gives you a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the *Evidence of Coverage*.

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Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service representative at 1-877-842-7564 (TTY: 711). We are open October 1 – March 31, daily, 8 a.m. to 8 p.m., local time, Monday through Friday. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays.

Understanding the Benefits

- ☐ Review the full list of benefits found in the *Evidence of Coverage* (EOC), especially for those services for which you routinely see a doctor. Call Customer Service at 1-877-299-1008 (TTY: 711) to request a copy of the EOC.
- ☐ Review the *Provider Finder* (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the *Pharmacy Directory* to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ Effect on Current Coverage. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- ☐ You must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2028
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the *Provider Finder*).

1 SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the *Evidence of Coverage*. Members can also see the *Evidence of Coverage* on our website, https://www.bcbstx.com/retiree-medicare-pebc or contact Customer Service at 1-877-299-1008 (TTY: 711).

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Blue Cross Group Medicare Advantage (HMO)**).

Tips for comparing your Medicare choices

This *Summary of Benefits* booklet gives you a summary of what **Blue Cross Group Medicare Advantage (HMO)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their *Summary of Benefits* booklets. Or use the Medicare Plan Finder on www.medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this booklet

- Things to Know About **Blue Cross Group Medicare Advantage (HMO).**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services.
- Covered Medical and Hospital Benefits.
- Prescription Drug Benefits.

This document is available in other formats such as Braille, large print, or audio.

This document may be available in a non-English language. For additional information, call us at 1-877-299-1008 (TTY: 711).

Things to Know About Blue Cross Group Medicare Advantage (HMO)

Hours of Operation & Contact Information

- From October 1 to March 31, we are open 8 a.m. – 8 p.m., local time, 7 days a week.
- From April 1 to September 30, we are open 8 a.m. – 8 p.m., local time, Monday through Friday. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays.
- If you are a member of this plan, call us at 1-877-299-1008, (TTY: 711).
- If you are not a member of this plan, call us at 1-877-842-7564, (TTY: 711).
- Our website: https://www.bcbstx.com/retiree-medicare-pebc.

Who can join?

To join **Blue Cross Group Medicare Advantage (HMO)**, you must have both Medicare Part A and Medicare Part B, meet your employer's eligibility requirements, and be retired. Our service area includes the state of Texas.

Which doctors, hospitals, and pharmacies can I use?

Blue Cross Group Medicare Advantage (HMO) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's *Provider Finder* and *Pharmacy Directory* at our website (https://www.bcbstx.com/retiree-medicare-pebc).

Or call us at 1-877-299-1008 (TTY: 711) and we will send you a copy of the *Provider Directory* and *Pharmacy Directory*.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers – and more. Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs including chemotherapy and some drugs administered by your provider.

- Formulary Name: 5 Tier Premier
- You can see the complete plan *Formulary* (list of Part D prescription drugs) and any restrictions on our website, https://www.bcbstx.com/retiree-medicare-pebc.
- Or call us at 1-877-299-1008 (TTY: 711) and we will send you a copy of the *Formulary*.

How will I determine my drug costs?

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage and Catastrophic Coverage.

If you have any questions about this plan's benefits or costs, please contact Blue Cross and Blue Shield of Texas

2 SECTION II - SUMMARY OF BENEFITS

Blue Cross Group Medicare Advantage (HMO)SM

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
Monthly Plan Premium	For information concerning the actual premiums you will pay, please contact your employer or your employer group benefits plan administrator. In addition, you must keep paying your Medicare Part B premium.
Deductible	This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility	If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs. Your yearly limit(s) in this plan: • $6,700 for services you receive from in-network providers.
COVERED MEDICAL AND HOSPITAL BENEFITS	
Inpatient Hospital	Our plan covers unlimited number of days for an inpatient hospital stay. **In-Network:** $250 copay per stay. May require prior authorization.
Outpatient Hospital	**In-Network:** $125 copay. May require prior authorization.

Ambulatory Surgical Center	**<u>In-Network:</u>** $125 copay. May require prior authorization.
Doctor's Office Visits	**<u>In-Network:</u>** Primary care physician visit: $20 copay. Specialist visit: $40 copay. May require prior authorization.
Preventive Care *(e.g., flu vaccine, diabetic screenings)*	**<u>In-Network:</u>** $0 copay for all preventive services covered under Original Medicare at zero cost sharing. **Important Message About What You Pay for Vaccines** Our plan covers most Part D vaccines at no cost to you. Call Customer Service for more information.
Emergency Care	$50 copay per visit. Worldwide Emergency Coverage: $50 copay. Copay is waived if you are admitted to the hospital within 3 days for the same condition. See the "Inpatient Hospital" section of this booklet for other costs.
Urgently Needed Services	$20 copay per visit. Worldwide Urgent Coverage: $20 copay.
Diagnostic Services / Labs/ Imaging	**<u>In-Network:</u>** Diagnostic tests and procedures: $0 copay. Lab services: $0 copay. MRIs, CT scans: $0 copay. X-rays: $0 copay. Therapeutic radiology services (such as radiation treatment for cancer): $0 copay. May require prior authorization.

Hearing Services	**<u>In-Network:</u>** **<u>Medicare-covered:</u>** Exam to diagnose and treat hearing and balance issues: $40 copay. **<u>Routine Hearing:</u>** Routine hearing exam (1 each year): $0 copay. **<u>Hearing Aid:</u>** $500 Allowance for both ears combined on hearing aids every three years. May require prior authorization.
Dental Services	**<u>In-Network:</u>** Medicare-covered: $40 copay. May require prior authorization.
Vision Services	**<u>In-Network:</u>** **<u>Medicare-covered:</u>** • Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $40 copay for an eye exam. • Eyeglasses or contact lenses after cataract surgery: $0 copay. **<u>Routine Vision:</u>** • Routine eye exam (1 every year): $40 copay. May require prior authorization.
Mental Health Services	Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you are admitted as an inpatient and ends when you have not received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods. **<u>In-Network:</u>** Inpatient Mental Health Care: $250 copay per stay.

	Outpatient group therapy visit: $40 copay. Outpatient Individual therapy visit: $40 copay. May require prior authorization.
Skilled Nursing Facility (SNF)	**In-Network:** Days 1-20: $0 copay per day. Days 21-100: $50 copay per day. May require prior authorization.
Physical Therapy	**In-Network:** $40 copay. May require prior authorization.
Outpatient Rehabilitation	**In-Network:** Cardiac rehab services (Maximum of 2 one-hour sessions per day up to 36 sessions in 36 weeks. Limit to 36 per year): $0 copay. Occupational therapy visit: $40 copay. May require prior authorization.
Ambulance	Ground Ambulance: $50 copay for each one-way trip. Air Ambulance: $50 copay for each one-way trip. May require prior authorization.
Transportation	$0 copay. 12 one-way trips every year to plan-approved locations. May require prior authorization.
Medicare Part B Drugs	**In-Network:** For Part B drugs such as chemotherapy drugs: 0% of the total cost. Other Part B drugs: 0% of the total cost. For Part B Insulin Drugs: 0% of the total cost with a maximum copay amount per month of $35. May require prior authorization.

<table>
<tr><th colspan="2">PRESCRIPTION DRUG BENEFITS</th></tr>
<tr><td>Deductible</td><td>Prescription Drug Deductible: This plan does not have a deductible.
Important Message About What You Pay for Insulin
You won’t pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.</td></tr>
<tr><td>Initial Coverage</td><td>You pay the following until your yearly out-of-pocket drug costs reach $2,400.
<table>
<tr><th colspan="3">Retail Cost-Sharing</th></tr>
<tr><th>Tier</th><th>One-month supply</th><th>Three-month supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$10 copay</td><td>$30 copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$10 copay</td><td>$30 copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>$20 copay</td><td>$60 copay</td></tr>
<tr><td>Tier 4 (Non-Preferred Drug)</td><td>$40 copay</td><td>$120 copay</td></tr>
<tr><td>Tier 5 (Specialty)</td><td>$40 copay</td><td>$120 copay</td></tr>
<tr><th colspan="3">Mail Order</th></tr>
<tr><th>Tier</th><th>One-month supply</th><th>Three-month supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$10 copay</td><td>$20 copay</td></tr>
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<tr><td>Tier 5 (Specialty)</td><td>$40 copay</td><td>$80 copay</td></tr>
</table></td></tr>
<tr><td>Long-term Care Tiers 1-5</td><td>If you reside in a long-term care facility, you pay the same as at a retail pharmacy.</td></tr>
<tr><td>Out-of-network Tiers 1-5</td><td>You may get drugs from an out-of-network pharmacy in specific situations. You generally must use a network pharmacy to fill your prescription.</td></tr>
<tr><td>Catastrophic Coverage</td><td>After your yearly out-of-pocket drug costs reach $2,400, you pay nothing for covered Part D drugs.</td></tr>
</table>

Please note: Federal law prohibits individuals enrolled in Medicare from using manufacturer coupons or other drug discounts with their drug plan. Financial assistance to help with the costs of prescription drugs may be available through the government's Extra Help/Low Income Subsidy program. You can apply for Extra Help any time before or after you enroll in Part D. For more information or to apply, visit the Social Security website at www.ssa.gov and click "Medicare," then "Apply for Part D Extra Help."

Additional Member Benefits	Blue Cross Group Medicare Advantage (HMO)[SM]
Acupuncture for Chronic Low Back Pain	**In-Network:** **Medicare-covered:** • 20% of the total cost. **Routine Acupuncture:** • Routine acupuncture: Not Covered. May require prior authorization.
Chiropractic Care	**Medicare-covered manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position).** **In-Network:** **Medicare-covered:** • 40% of the total cost. **Routine Chiropractic Care:** • Routine chiropractic: Not Covered. May require prior authorization.
Diabetes Supplies and Services	**In-Network:** **Diabetes monitoring supplies** • You will pay 0% for all diabetic testing supplies (meters, test strips, and lancets) obtained through the pharmacy. **Diabetes self-management training** • $0 copay. **Therapeutic shoes or inserts** • 0% of the total cost. **Diabetic Monitors** • 0% of the total cost for Preferred Monitors. • 0% of the total cost for Non Preferred Monitors.

Additional Member Benefits	Blue Cross Group Medicare Advantage (HMO)[SM]
	May require prior authorization.
Durable Medical Equipment ***(wheelchairs, oxygen, etc.)***	**In-Network:** • $0 copay. May require prior authorization.
Wellness Programs	$0 copay for Fitness Program The fitness benefit can help you live a healthier, more active life through fitness and social connection. You are covered for a fitness benefit both online and at participating locations. You have access to a nationwide network of participating locations where you can take classes.
Foot Care ***(Podiatry services)***	**Medicare-covered foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.** **In-Network:** **Medicare-covered:** • $40 copay. **Routine Podiatry:** • Routine podiatry: Not Covered. May require prior authorization.
Private Duty Nursing	**In-Network:** $0 copay for Non Medicare-covered services. (40 visits per year) For more details on benefits and benefit limitations regarding your private duty nursing coverage, please see your *Evidence of Coverage*.
Home Health Care	**In-Network:** • $0 copay.

Additional Member Benefits	Blue Cross Group Medicare Advantage (HMO)[SM]
	May require prior authorization.
Opioid Treatment Program Services	**<u>In-Network:</u>** • $0 copay. May require prior authorization.
Outpatient Substance Abuse Services	**<u>In-Network:</u>** **Group therapy visit** • $40 copay. **Individual therapy visit** • $40 copay. May require prior authorization.
Over-the-Counter Items	Not Covered
Prosthetic Devices *(braces, artificial limbs, etc.)*	**<u>In-Network:</u>** **Prosthetic devices** • $0 copay. **Related medical supplies** • $0 copay. May require prior authorization.
Meals	Eligible members will receive 28 meals for 14 days after a qualifying inpatient hospital or skilled nursing facility stay. Max 3 times per year. This benefit does not apply to releases from an emergency room, observation stay or outpatient visit. May require prior authorization.

Additional Member Benefits	Blue Cross Group Medicare Advantage (HMO)[SM]
Renal Dialysis	**In-Network:** • $0 copay. May require prior authorization.
Telehealth Services	• $0 copay Virtual Urgent Care (through the HCSC telehealth vendor only), $40 copay Virtual Mental Health Specialty Services (through the HCSC telehealth vendor only), $40 copay Virtual Psychiatric Services (through the HCSC telehealth vendor only)
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the total costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.

DISCLAIMERS

This document is available in other alternate formats.

We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-299-1008 (TTY: 711). Someone who speaks Spanish can help you. This is a free service.

This information is not a complete description of benefits. Call 1-877-299-1008 (TTY: 711) for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.

You must continue to pay your Medicare Part B premium.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Out-of-network/non-contracted providers are under no obligation to treat Blue Cross and Blue Shield of Texas members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our Customer Service number or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.

Premium, copays, coinsurance, and deductibles may vary based on the level of Extra Help you receive. Please contact the plan for further details.

HMO employer/union group plans are provided by HCSC Insurance Services Company (HISC)-H9706 and GHS Insurance Company (GHSIC)-H8133 and H8544. HISC and GHSIC are Independent Licensees of the Blue Cross and Blue Shield Association. HISC and GHSIC are Medicare Advantage organizations with Medicare contracts. Enrollment in these plans depends on contract renewal.

Benefits, features and/or devices vary by plan/service area. Limitations, copayments, exclusions and restrictions may apply. Contact the plan for more information.

Limitations, copayments, exclusions and restrictions may apply. Individuals must live in the plan service area. Benefits vary by plan. Prior authorization and/or referrals are required for certain services.

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 1-877-299-1008 (TTY: 711).

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	Phone: 1-855-664-7270 (voicemail)
Attn: Office of Civil Rights Coordinator	TTY/TDD: 1-855-661-6965
300 E. Randolph St., 35th Floor	Fax: 1-855-661-6960
Chicago, IL 60601	Email: civilrightscoordinator@hcsc.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:

US Dept of Health & Human Services	Phone: 1-800-368-1019
200 Independence Avenue SW	TTY/TDD: 1-800-537-7697
Room 509F, HHH Building	Complaint Portal:
Washington, DC 20201	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 bcbstx.com/legal-and-privacy/non-discrimination-notice.

Blue Cross Blue Shield of Texas, A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

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 1-877-299-1008 (TTY: 711). Hours are 8 a.m. – 8 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays. 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 1-877-299-1008 (TTY: 711) o hable con su proveedor.
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 1-877-299-1008 (TTY: 711) أو تحدث إلى مقدم الخدمة.
中文 Chinese	注意：如果您说[中文]，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 1-877-299-1008（文本电话：711）或咨询您的服务提供商。
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 1-877-299-1008 (TTY : 711) ou parlez à votre fournisseur.
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 1-877-299-1008 (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 સંપૂર્ણ મૂલ્યે ઉપલબ્ધ છે. 1-877-299-1008 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.
हिंदी Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएँ उपलब्ध हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयोगी सामाजिक उपकरण और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-877-299-1008 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।
Italiano Italian	ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'1-877-299-1008 (TTY: 711) o parla con il tuo fornitore.
한국어 Korean	주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-877-299-1008 (TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.
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' 1-877-299-1008 (TTY: 711) hodíilnih doodago nika'análwo'í bich'į' hanidziih.
فارسی Farsi	توجه: اگر [وارد کردن زبان] 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 1-877-299-1008 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود

Polski Polish	UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-877-299-1008 (TTY: 711) lub porozmawiaj ze swoim dostawcą.
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 1-877-299-1008 (TTY: 711) или обратитесь к своему поставщику услуг.
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 1-877-299-1008 (TTY: 711) o makipag-usap sa iyong provider.
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۔ (TTY: 711) 1-877-299-1008 پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔
فارسی Persian	ما در راستای پاسخگویی به سؤالات شما در مورد طرح سلامت یا دارویی خود، دارای خدمات مترجم رایگان هستیم. برای داشتن یک مترجم، کافیست از طریق شماره 1-877-299-1008 (TTY: 711) با ما تماس بگیرید. یک شخص فارسی زبان می‌تواند به شما کمک کند. این یک سرویس رایگان است
ລາວ Laotian	ພວກເຮົາ ມີ ບໍ ລິ ການຜູ້ ແປພາສາບໍ່ ເສຍຄ່າໃຫ້ເພື ອຄອຍຕອບ ໍຄາຖາມທີ ທ່ານອາດມີ ກ່ຽວກັ ບແຜນປະກັ ນສຸ ຂະພາບ ແລະ ຍາຂອງພວກເຮົ າ. ເພື ອຄ ວາມ ຜູ້ ແປພາສາ, ພຽງແຕ່ໂທຫາພວກເຮົ າທີ່ ເບີ 1-877-299-1008 (TTY: 711). ຈະມີ ຄ ນທີ່ ເວ ້ າພາສາລາວສາມາດຊ່ວຍທ່ານໄດ ້. ນ ້ ແມ ນການບ ລິ ການບ່ ເສຍຄ່າ.
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 1-877-299-1008 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

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