



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, visit

www.bcbstx.com/bb/ind/bb_so3h30bavitxp_tx_2026.pdf or by calling 1-888-697-0683. 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 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
<u>What is the overall deductible?</u>	\$0 at Indian Health Care <u>Provider</u> or with IHCP <u>referral</u> at non-IHCP; or <u>Network</u> : \$1,250 Individual / \$2,500 Family Out-of-Network: \$15,000 Individual / \$45,000 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<u>Are there services covered before you meet your deductible?</u>	Yes. Services from Indian Health Care Providers, In-Network Preventive Health Care services, certain services with a <u>copayment</u> , and certain <u>prescription drugs</u> are covered before you meet your deductible.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
<u>Are there other deductibles for specific services?</u>	No.	You don't have to meet <u>deductibles</u> for specific services.
<u>What is the out-of-pocket limit for this plan?</u>	<u>Network</u> : \$10,500 Individual / \$21,000 Family Out-of-Network: Unlimited Individual / Unlimited Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<u>What is not included in the out-of-pocket limit?</u>	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<u>Will you pay less if you use a network provider?</u>	Yes. See www.bcbstx.com/go/bahmo or call 1-888-697-0683 for a list of <u>Participating providers</u> .	You pay the least if you use a <u>provider</u> in IHCP <u>Network</u> . You pay more if you use a <u>provider</u> in Non-IHCP <u>Network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<u>Do you need a referral to see a specialist?</u>	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



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
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP 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	No Charge	\$25/visit; deductible does not apply	50% coinsurance	Virtual Visits are available. See your benefit booklet* (Your PCP) for details.
	<u>Specialist</u> visit	No Charge	50% coinsurance	50% coinsurance	<u>Referral</u> required. <u>Cost sharing</u> waived at non-IHCP with <u>IHCP referral</u> .
	<u>Preventive</u> care/ <u>screening</u> / <u>immunization</u>	No Charge	No Charge; deductible does not apply	50% coinsurance	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No Charge	Freestanding Facility: 30% coinsurance Hospital: 50% coinsurance	50% coinsurance	<u>Referral</u> may be required. <u>Preauthorization</u> may also be required; see your benefit booklet* (Outpatient Lab and X-Ray services) for details. <u>Cost sharing</u> waived at non-IHCP with <u>IHCP referral</u> .
	Imaging (CT/PET scans, MRIs)	No Charge	Freestanding Facility: 30% coinsurance Hospital: 50% coinsurance	50% coinsurance	<u>Referral</u> may be required. <u>Preauthorization</u> may also be required; See your benefit booklet* (Outpatient Lab and X-Ray services) for details. <u>Cost sharing</u> waived at non-IHCP with <u>IHCP referral</u> .
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at	Generic drugs (Preferred)	No Charge	Retail: Preferred Participating - \$5/prescription Participating - \$10/prescription Mail: \$15/prescription; deductible does not apply	Retail: \$10/prescription; deductible does not apply plus 50% additional charge	Limited to a 30-day supply at retail (or a 90-day supply at a <u>network</u> of select retail pharmacies). Up to a 90-day supply at mail order. <u>Specialty drugs</u> limited to a 30-day supply except for certain FDA-designated dosing regimens. Payment of the difference between the cost of a brand name drug and a generic may also be required if a generic drug is available.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
www.bcbstx.com/rx26/6T	Generic drugs (Non-Preferred)	No Charge	Retail: Preferred Participating - \$15/prescription Participating - \$25/prescription Mail: \$45/prescription; <u>deductible</u> does not apply	Retail: \$25/prescription; <u>deductible</u> does not apply plus 50% additional charge	Additional Out-of-Network charge will not apply to any <u>deductible</u> or out-of-pocket amounts. Certain drugs require approval before they will be covered. <u>Cost sharing</u> for insulin included in the drug list will not exceed \$25 per prescription for a 30-day supply, regardless of the amount or type of insulin needed to fill the prescription.
	Brand drugs (Preferred)	No Charge	Retail: Preferred Participating - 30% <u>coinsurance</u> Participating - 35% <u>coinsurance</u> Mail: 30% <u>coinsurance</u>	Retail: 35% <u>coinsurance</u> plus 50% additional charge	
	Brand drugs (Non-Preferred)	No Charge	Retail: Preferred Participating - 35% <u>coinsurance</u> Participating - 40% <u>coinsurance</u> Mail: 35% <u>coinsurance</u>	Retail: 40% <u>coinsurance</u> plus 50% additional charge	
	<u>Specialty drugs</u> (Preferred)	No Charge	45% <u>coinsurance</u>	45% <u>coinsurance</u> plus 50% additional charge	
	<u>Specialty drugs</u> (Non-Preferred)	No Charge	50% <u>coinsurance</u>	50% <u>coinsurance</u> plus 50% additional charge	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Freestanding Facility: \$600/visit plus 30% <u>coinsurance</u> Hospital: \$600/visit plus 50% <u>coinsurance</u>	\$2,000/visit plus 50% <u>coinsurance</u>	Referral required. Preauthorization may also be required. For Outpatient Infusion Therapy, see your benefit booklet* (Outpatient Facility Services) for details. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> .
	Physician/surgeon fees	No Charge	\$200/visit plus 50% <u>coinsurance</u>	50% <u>coinsurance</u>	

*For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com/bb/ind/bb_so3h30bavitxp_tx_2026.pdf

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	No Charge	\$1,000/visit plus 50% coinsurance	\$1,000/visit plus 50% coinsurance	<u>Copayment</u> waived if admitted. <u>Cost sharing</u> waived at non-IHCP with IHCP referral.
	<u>Emergency medical transportation</u>	No Charge	50% coinsurance	50% coinsurance	<u>Preauthorization</u> may be required for non-emergency transportation; see your benefit booklet* (Ambulance Services) for details. <u>Cost sharing</u> waived at non-IHCP with IHCP referral.
	<u>Urgent care</u>	No Charge	\$40/visit; <u>deductible</u> does not apply	50% coinsurance	<u>Cost sharing</u> waived at non-IHCP with IHCP referral.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	\$950/visit plus 50% coinsurance	\$2,000/visit plus 50% coinsurance	<u>Referral</u> required. <u>Preauthorization</u> may also be required; see your benefit booklet* (Inpatient Hospital Services) for details. <u>Cost sharing</u> waived at non-IHCP with IHCP referral.
	Physician/surgeon fees	No Charge	50% coinsurance	50% coinsurance	<u>Referral</u> required. <u>Preauthorization</u> may also be required; see your benefit booklet* (Inpatient Professional Services) for details. <u>Cost sharing</u> waived at non-IHCP with IHCP referral.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	50% coinsurance for office visits; 30% coinsurance for other outpatient services	50% coinsurance	<u>Preauthorization</u> may be required; See your benefit booklet* (Behavioral Health Services) for details. <u>Cost sharing</u> waived at non-IHCP with IHCP referral.
	Inpatient services	No Charge	\$950/visit plus 50% coinsurance	\$2,000/visit plus 50% coinsurance	<u>Referral</u> required. <u>Preauthorization</u> may also be required; see your benefit booklet* (Behavioral Health Services) for details. <u>Cost sharing</u> waived at non-IHCP with IHCP referral.
If you are pregnant	Office visits	No Charge	Primary Care: \$25/initial visit; <u>deductible</u> does not apply <u>Specialist</u> : 50% coinsurance	50% coinsurance	

*For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com/bb/ind/bb_so3h30bavitxp_tx_2026.pdf

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	No Charge	50% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Copayment</u> applies to first prenatal visit (per pregnancy). <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> .
	Childbirth/delivery facility services	No Charge	\$950/visit plus 50% <u>coinsurance</u>	\$2,000/visit plus 50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	No Charge	50% <u>coinsurance</u>	50% <u>coinsurance</u>	60 visits/year. <u>Referral</u> required. <u>Preauthorization</u> may also be required; see your benefit booklet* (Extended Care Services) for details. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> .
	<u>Rehabilitation services</u>	No Charge	50% <u>coinsurance</u>	50% <u>coinsurance</u>	Separate 35-visit maximum per benefit period for <u>Habilitation services</u> and <u>Rehabilitation services</u> , including chiropractic care. <u>Referral</u> required. <u>Preauthorization</u> may also be required; See your benefit booklet* (Rehabilitation Services and Habilitation Services) for details. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> .
	<u>Habilitation services</u>	No Charge	50% <u>coinsurance</u>	50% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	No Charge	50% <u>coinsurance</u>	50% <u>coinsurance</u>	25 days/year. <u>Referral</u> required. <u>Preauthorization</u> may also be required; see your benefit booklet* (Extended Care Services) for details. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> .
	<u>Durable medical equipment</u>	No Charge	50% <u>coinsurance</u>	50% <u>coinsurance</u>	

*For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com/bb/ind/bb_so3h30bavitxp_tx_2026.pdf

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
	<u>Hospice services</u>	No Charge	50% <u>coinsurance</u>	50% <u>coinsurance</u>	Referral required. <u>Preauthorization</u> may also be required; see your benefit booklet* (Extended Care Services) for details. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> .
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge; <u>deductible</u> does not apply	Up to a \$30 reimbursement is available	One visit per year. Out-of-Network reimbursement will not exceed the retail cost. See your benefit booklet* (Pediatric Vision Care Benefits) for details.
	Children's glasses	No Charge	No Charge; <u>deductible</u> does not apply	Up to a \$75 reimbursement is available	One pair of glasses per year. Reimbursement for frames, lenses, and lens options purchased Out-of-Network is available (not to exceed the retail cost). See your benefit booklet* (Pediatric Vision Care Benefits) for details.
	Children's dental check-up	Not Covered	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.)

- Abortion (Except for a pregnancy that, as certified by a physician, places the woman in danger of death)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery (Except when medically necessary)
- Dental care (Adult and child)
- Infertility treatment (Diagnosis and treatment covered; in vitro not covered)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (Unless medically necessary)
- Routine eye care (Adult)
- Routine foot care (Except when medically necessary)
- Weight loss programs

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

- Chiropractic care (35 visits/year combined with habilitation and rehabilitation services)
- Hearing aids (Limited to 1 hearing aid per ear every 36 months)

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 plan at Blue Cross and Blue Shield of Texas at 1-888-697-0683 or visit www.bcbstx.com. You may also contact your state insurance department at 1-800-252-3439 or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 OR state Health Insurance Marketplace or SHOP.

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 on how 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: Texas Department of Insurance at 1-800-578-4677 or visit <https://tdi.texas.gov>.

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? Not Applicable.

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 1-888-697-0683.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-697-0683.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-697-0683.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-888-697-0683.

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
- Specialist copayment
- Hospital (facility) copayment
- Other coinsurance

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	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$60

Managing Joe's Type 2 Diabetes

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

- The plan's overall deductible
- Specialist copayment
- Hospital (facility) copayment
- Other coinsurance

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	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$20

Mia's Simple Fracture

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

- The plan's overall deductible
- Specialist copayment
- Hospital (facility) copayment
- Other coinsurance

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	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$0

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-866-236-1702.

Note: These numbers assume the patient received care from an IHCP providers or with IHCP referral at a non-IHCP. If you receive care from a non-IHCP providers without a referral from an IHCP your costs may be higher.

The plan would be responsible for the other costs of these EXAMPLE covered 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 855-710-6984.

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

US Dept of Health & Human Services	Phone:	800-368-1019
200 Independence Avenue SW	TTY/TDD:	800-537-7697
Room 509F, HHH Building	Complaint Portal:	ocrportal.hhs.gov/ocr/smartscreen/main.jsf
Washington, DC 20201	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



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 855-710-6984 (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 855-710-6984 (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 مبنية لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجلًا. اتصل على الرقم 855-710-6984 (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 855-710-6984（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 855-710-6984 (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 855-710-6984 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.
ગુજરાતી Gujarati	ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાચીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. થોય ઓફિશિલ સહાય અને એક્સેસિબલ ફોર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મુખ્ય ઉપલબ્ધ છે. 855-710-6984 (TTY: 711) પર કોણ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.
हिन्दी Hindi	ध્યાન દें: યदि આપ હિન્દી બोલતો હોય, તો આપકે લિએ નિઃશુલ્ક ભાષા સહાયતા સેવાએ ઉપલબ્ધ હોતી હોયાં। સુલમ પ્રારૂપો મેં જાનકારી પ્રદાન કરને કે લિએ ઉપયુક્ત સહાયક સાધન ઔર સેવાએ મિનિઃશુલ્ક ઉપલબ્ધ હોયાં। 855-710-6984 (TTY: 711) પર કોણ કરો અથવા અપને પ્રદાતા સાથે વાત કરો।
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'855-710-6984 (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. 855-710-6984(TTY: 711)으로 전화하거나 서비스 제공업체에 문의하십시오.
Diné Navajo	SHOOH: Diné bee yáñilti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hólq. Bee ahil hane'go bee nida'anishí t'áá ákodaata'éhígíi dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadílyaa bich'í[ahoot'í'gíí éí t'áá jiik'eh hólq. Kohji' 855-710-6984 (TTY: 711) hodiilnih doodago nika'análwo'í bich'í[hanidzih.
فارسی Farsi	توجه: اگر فارسی صحبت می کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمکها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب های قابل دسترس، به طور رایگان موجود می باشند. با شماره 855-710-6984 (تلنامبر: 711) تماس بگیرید یا با ازایده نهاده خود صحبت کنید.
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 855-710-6984 (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 855-710-6984 (TTY: 711) или обратитесь к своему поставщику услуг.
Tagalog Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyon 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 855-710-6984 (TTY: 711) o makipag-usap sa iyong provider.
اردو Urdu	توجه: اگر آپ اردو بولجئ پئیں، تو آپ کے لئے زبان کی مفت مدد کی خدمات دستیاب پئیں۔ قابل رسائی فارمیشنس میں معلومات فراہم کرنے کے لئے مناسب معاون امداد اور خدمات بھی مفت دستیاب پئیں۔ 855-710-6984 (TTY: 711) پر کال کریں۔
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 855-710-6984 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.