**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/tx/documents/bbf/bb/2027/bb_atbcb605_tx_2027.pdf or by calling 1-800-521-2227. For 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: |
|---|---|---|
| **What is the overall deductible?** | Network: $2,000 Individual/$6,000 Family<br>Out-of-Network: $4,000 Individual/$12,000 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. Network office visits, hospice services, prescription drugs, preventive care services and certain services with a copayment 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?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | Network: $6,000 Individual/$18,000 Family<br>Out-of-Network: Unlimited Individual/Unlimited Family | 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?** | Premiums, balance billing charges, and health care this plan doesn't cover. | 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.bcbstx.com/go/bcppo or call 1-800-810-2583 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 an out-of-network 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). Be aware, your network provider might use an out-of-network 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. | You can see the specialist you choose without a referral. |

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 |
|---|---|---|---|---|
| | | Participating Provider (You will pay the least) | Non-Participating 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 | $35 copayment/visit; deductible does not apply | 40% coinsurance | Virtual visits are available. See your benefit booklet* for details. |
| | Specialist visit | $70 copayment/visit; deductible does not apply | 40% coinsurance | None |
| | Preventive care/screening/ immunization | No Charge; deductible does not apply | 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) | 20% coinsurance | 40% coinsurance | Inpatient: Certain services may require prior authorization for Out-of-Network; failure to preauthorize may result in $250 reduction in benefits. Outpatient: Certain services may require prior authorization for Out-of-Network; failure to preauthorize may result in 50% reduction in benefits not to exceed $500; see your benefit booklet* for details. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.bcbstx.com/prescription-drugs/managing-prescriptions/drug-lists | Generic drugs (Preferred) | Retail - Preferred - No Charge Non-Preferred - $10 copayment/prescription Mail - No Charge; deductible does not apply | Retail - $10 copayment/prescription; deductible does not apply plus 50% additional charge | Limited to a 30-day supply at retail (or a 90-day supply at a network of select retail pharmacies). Up to a 90-day supply at mail order. Specialty drugs 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. Additional charge will not apply to any deductible or out-of-pocket amounts. |
| | Generic drugs (Non-preferred | Retail - Preferred - $10 copayment/prescription Non-Preferred - $20 copayment/prescription Mail - $30 copayment/prescription; deductible does not apply | Retail - $20 copayment/prescription; deductible does not apply plus 50% additional charge | |

*For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com/tx/documents/bbf/bb/2027/bb_atbcb605_tx_2027.pdf.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| | Brand drugs (Preferred) | Retail - Preferred - $50 copayment/prescription<br>Non-Preferred - $70 copayment/prescription<br>Mail - $150 copayment/prescription; deductible does not apply | Retail - $70 copayment/prescription; deductible does not apply plus 50% additional charge | Certain drugs require approval before they will be covered. Cost sharing 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 (Non-preferred) | Retail - Preferred - $100 copayment/prescription<br>Non-Preferred - $120 copayment/prescription<br>Mail - $300 copayment/prescription; deductible does not apply | Retail - $120 copayment/prescription; deductible does not apply plus 50% additional charge | |
| | Specialty drugs (Preferred) | $150 copayment/prescription; deductible does not apply | $150 copayment/prescription; deductible does not apply plus 50% additional charge | |
| | Specialty drugs (Non-preferred) | $250 copayment/prescription; deductible does not apply | $250 copayment/prescription; deductible does not apply plus 50% additional charge | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance | Certain services may require prior authorization for Out-of-Network; failure to preauthorize may result in 50% reduction in benefits not to exceed $500.<br>For Outpatient Infusion Therapy, see your benefit booklet* for details. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | |
| **If you need immediate medical attention** | Emergency room care | $500 copayment/visit plus 20% coinsurance | $500 copayment/visit plus 20% coinsurance | Copayment waived if admitted. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | None |
| | Urgent care | $75 copayment/visit; deductible does not apply | 40% coinsurance | |

*For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com/tx/documents/bbf/bb/2027/bb_atbcb605_tx_2027.pdf.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | Prior authorization required. Prior authorization penalty: $250 Out-of-Network. See your benefit booklet* for details. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $35 copayment/office visit; deductible does not apply or 20% coinsurance for other outpatient services | 40% coinsurance | Certain services must be preauthorized, failure to preauthorize at least two business days prior to service will result in 50% reduction in benefits (not to exceed $500), refer to benefit booklet* for details. |
| | Inpatient services | 20% coinsurance | 40% coinsurance | Prior authorization required Out-of-Network; failure to preauthorize at least two business days prior to admission will result in $250 reduction in benefits. |
| **If you are pregnant** | Office visits | Primary Care: $35 copayment/initial visit Specialist: $70 copayment/initial visit; deductible does not apply | 40% coinsurance | Copayment applies to first prenatal visit (per pregnancy). Cost sharing does not apply to preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
| | Childbirth/delivery professional services | 20% coinsurance | 40% coinsurance | |
| | Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 40% coinsurance | 60 visits/year. Prior authorization may be required for Out-of-Network. Failure to preauthorize may result in 50% reduction in benefits not to exceed $500. See your benefit booklet* for details. |
| | Rehabilitation services | 20% coinsurance | 40% coinsurance | For Outpatient, limited to combined 35 visits per year, including Chiropractic. |
| | Habilitation services | 20% coinsurance | 40% coinsurance | |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | 25-day maximum per calendar year. Prior authorization may be required for Out-of-Network. Failure to preauthorize may result in $250 reduction in benefits. See your benefit booklet* for details. |

*For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com/tx/documents/bbf/bb/2027/bb_atbcb605_tx_2027.pdf.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | None |
| | Hospice services | No Charge; deductible does not apply | 40% coinsurance | Inpatient: Prior authorization may be required for Out-of-Network; failure to preauthorize may result in a $250 reduction in benefits.<br>Outpatient: Prior authorization may be required for Out-of-Network; failure to preauthorize may result in 50% reduction in benefits not to exceed $500. See your benefit booklet* for details. |
| **If your child needs dental or eye care** | Children's eye exam | Not Covered | Not Covered | None |
| | Children's glasses | Not Covered | Not Covered | None |
| | Children's dental check-up | Not Covered | Not Covered | |

*For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com/tx/documents/bbf/bb/2027/bb_atbcb605_tx_2027.pdf.

## 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 individual in danger of death)
- Acupuncture
- Cosmetic surgery
- Dental care (Adult and Child)
- Long-term care
- Most coverage provided outside the United States. See www.bcbstx.com
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care (Outpatient – max. 35 visits/year)
- Hearing aids (Limited to one hearing aid per ear every 36 months)
- Infertility treatment (In vitro and artificial insemination are not covered unless shown in your plan document)
- Routine eye care (Adult)
- Routine foot care (Only covered in connection with diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency)

**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: For group health coverage contact the plan, Blue Cross and Blue Shield of Texas at 1-800-521-2227 or visit www.bcbstx.com. For group health coverage subject to ERISA, contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For non-federal governmental group health plans, contact Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law. 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 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: the Claim review section at Blue Cross and Blue Shield of Texas or visit www.bcbstx.com or the Texas Department of Insurance, or www.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?** **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 1-800-521-2227.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-521-2227.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-521-2227.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-521-2227.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-800-521-2227 uff.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-521-2227.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-521-2227.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-800-521-2227

***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** | **$2,000** |
| **Specialist copayment** | **$70** |
| **Hospital (facility) coinsurance** | **20%** |
| **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 | $2,000 |
| Copayments | $40 |
| Coinsurance | $2,100 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$4,200** |

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| **The plan's overall deductible** | **$2,000** |
| **Specialist copayment** | **$70** |
| **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 | $900 |
| Copayments | $700 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,620** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$2,000** |
| **Specialist copayment** | **$70** |
| **Hospital (facility) coinsurance** | **20%** |
| **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 | $2,000 |
| Copayments | $600 |
| Coinsurance | $20 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,620** |

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 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<br>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<br>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 855-710-6984 (TTY: 711) أو تحدث إلى مقدم الخدمة. |

**www.bcbstx.com**

Blue Cross and 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

**BlueCross BlueShield** of Texas

| | |
|---|---|
| 中文<br>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<br>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<br>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<br>Gujarati | ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઓક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 855-710-6984 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો. |
| हिंदी<br>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। 855-710-6984 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें। |
| Italiano<br>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 il 855-710-6984 (tty: 711) o parla con il tuo fornitore. |
| 한국어<br>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)번으로 전화하거나 서비스 제공업체에 문의하십시오. |
| Diné<br>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' 855-710-6984 (TTY: 711) hodíilnih doodago nika'análwo'í bich'į' hanidziih. |
| فارسی<br>Farsi | 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 855-710-6984 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید. |
| Polski<br>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<br>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<br>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 855-710-6984 (TTY: 711) o makipag-usap sa iyong provider. |
| اردو<br>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۔ 855-710-6984 (711:TTY) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔ |
| **Việt**<br>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.** |

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