**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/individual/bb/2027/bb_shsa03bftitxp_tx_2027.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: |
|---|---|---|
| **What is the overall deductible?** | $3,100 Individual / $6,200 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. In-Network Preventive Health Care services, certain services with a copayment, and certain prescription drugs 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?** | $10,550 Individual / $21,100 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/mbh or call 1-888-697-0683 for a list of Participating 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?** | Yes. | This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist. |

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 Providers (You will pay the least) | Non-Participating Providers (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 | Select PCP: No Charge; deductible does not apply<br>All other providers: $40/visit; deductible does not apply | Not Covered | To obtain No Charge, you must choose a Select Physician as your PCP (Primary Care Physician). Virtual Visits are available. See your benefit booklet* (Your PCP) for details. |
| | Specialist visit | $90/visit; deductible does not apply | Not Covered | Referral required. |
| | Preventive care/screening/ immunization | No Charge; deductible does not apply | Not Covered | 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) | Freestanding Facility (including bloodwork performed by a Select PCP): 30% coinsurance<br>Hospital (including bloodwork): 40% coinsurance<br>In Office: (Certain X-Rays, Ultrasounds, and ECGs ordered by Select PCP): No Charge; deductible does not apply | Not Covered | Referral may be required. Prior Authorization may also be required. Certain X-Rays, Ultrasounds, and ECGs as listed in our Schedule of Copayments and Benefit Limits in your benefit booklet are covered at No Charge in office with a Select PCP. To obtain No Charge, you must choose a Select Physician as your PCP, and the services must be performed in office with a Select PCP. See your benefit booklet* (Outpatient Lab and X-Ray services) for details. |
| | Imaging (CT/PET scans, MRIs) | Freestanding Facility: 30% coinsurance<br>Hospital: 40% coinsurance | Not Covered | Referral may be required. Prior Authorization may also be required; see your benefit booklet* (Outpatient Lab and X-Ray services) for details. |
| | Generic drugs (Preferred) | Retail: Preferred Participating - $5/prescription<br>Participating - $15/prescription<br>Mail: $15/prescription; deductible does not apply | Not Covered | 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- |

*For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com/tx/documents/individual/bb/2027/bb_shsa03bftitxp_tx_2027.pdf

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Participating Providers (You will pay the least) | Non-Participating Providers (You will pay the most) | |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.bcbstx.com/rx27/6T | Generic drugs (Non-Preferred) | Retail: Preferred Participating - $15/prescription<br>Participating - $25/prescription<br>Mail: $45/prescription; deductible does not apply | Not Covered | 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. 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 (Preferred) | Retail: Preferred Participating - $90/prescription<br>Participating - $115/prescription<br>Mail: $270/prescription; deductible does not apply | Not Covered | |
| | Brand drugs (Non-Preferred) | 45% coinsurance | Not Covered | |
| | Specialty drugs (Preferred) | 50% coinsurance | Not Covered | |
| | Specialty drugs (Non-Preferred) | 55% coinsurance | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Freestanding Facility: 30% coinsurance<br>Hospital: 40% coinsurance | Not Covered | Referral required. Prior Authorization may also be required. For Outpatient Infusion Therapy, see your benefit booklet* (Outpatient Facility Services) for details. |
| | Physician/surgeon fees | 40% coinsurance | Not Covered | |
| **If you need immediate medical attention** | Emergency room care | $2,500/visit; deductible does not apply | $2,500/visit; deductible does not apply | Copayment waived if admitted. |
| | Emergency medical transportation | 40% coinsurance | 40% coinsurance | Prior Authorization may be required for non-emergency transportation; see your benefit booklet* (Ambulance Services) for details. |
| | Urgent care | $60/visit; deductible does not apply | Not Covered | No Charge for first two (2) visits per benefit period with in-network provider. See your benefit booklet* for details. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 40% coinsurance | Not Covered | Referral required. Prior Authorization may also be required; see your benefit booklet* (Inpatient Hospital Services) for details. |

*For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com/tx/documents/individual/bb/2027/bb_shsa03bftitxp_tx_2027.pdf

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Participating Providers (You will pay the least) | Non-Participating Providers (You will pay the most) | |
| | Physician/surgeon fees | 40% coinsurance | Not Covered | Referral required. Prior Authorization may also be required; see your benefit booklet* (Inpatient Professional Services) for details. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $40/office visit; deductible does not apply;<br>40% coinsurance for other outpatient services | Not Covered | Prior Authorization may be required; see your benefit booklet* (Behavioral Health Services) for details. |
| | Inpatient services | 40% coinsurance | Not Covered | Referral required. Prior Authorization may also be required; see your benefit booklet* (Behavioral Health Services) for details. |
| **If you are pregnant** | Office visits | Primary Care: $40/initial visit; deductible does not apply<br>Specialist: $90/initial visit; deductible does not apply | Not Covered | Copayment applies to first prenatal visit (per pregnancy). Cost sharing does not apply for 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 | 40% coinsurance | Not Covered | |
| | Childbirth/delivery facility services | 40% coinsurance | Not Covered | |
| **If you need help recovering or have other special health needs** | Home health care | 40% coinsurance | Not Covered | 60 visits/year. Referral required. Prior Authorization may also be required; see your benefit booklet* (Extended Care Services) for details. |
| | Rehabilitation services | 40% coinsurance | Not Covered | Separate 35-visit maximum per benefit period for Habilitation services and Rehabilitation services, including chiropractic care. Referral required. Prior Authorization may also be required; see your benefit booklet* (Rehabilitation Services and Habilitation Services) for details. |
| | Habilitation services | 40% coinsurance | Not Covered | |

*For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com/tx/documents/individual/bb/2027/bb_shsa03bftitxp_tx_2027.pdf

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Participating Providers (You will pay the least) | Non-Participating Providers (You will pay the most) | |
| | Skilled nursing care | 40% coinsurance | Not Covered | 25 days/year. Referral required. Prior Authorization may also be required; see your benefit booklet* (Extended Care Services) for details. |
| | Durable medical equipment | 40% coinsurance | Not Covered | Referral required. Prior Authorization may also be required; see your benefit booklet* (Durable Medical Equipment) for details. |
| | Hospice services | 40% coinsurance | Not Covered | Referral required. Prior Authorization may also be required; see your benefit booklet* (Extended Care Services) for details. |
| **If your child needs dental or eye care** | Children's eye exam | No Charge; deductible 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; deductible 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 | None |

*For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com/tx/documents/individual/bb/2027/bb_shsa03bftitxp_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 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 (except when 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, kwiijigo holne' 1-888-697-0683.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-888-697-0683 uff.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-888-697-0683.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-888-697-0683.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 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** | **$3,100** |
| **Specialist copayment** | **$90** |
| **Hospital (facility) coinsurance** | **40%** |
| **Other coinsurance** | **40%** |

**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 | $3,100 |
| Copayments | $10 |
| Coinsurance | $3,700 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$6,870** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$3,100** |
| **Specialist copayment** | **$90** |
| **Hospital (facility) coinsurance** | **40%** |
| **Other coinsurance** | **40%** |

**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 | $600 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,520** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$3,100** |
| **Specialist copayment** | **$90** |
| **Hospital (facility) coinsurance** | **40%** |
| **Other coinsurance** | **40%** |

**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 | $2,100 |
| Copayments | $600 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,700** |

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



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

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. |
| 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 ઑક્ઝિલરી 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 l'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 yániłti'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. |
| فارسي<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 (TTY:711) 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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