



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, call 1-800-240-6430 or at www.bcbstx.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	For <u>In-Network</u> : EE Only \$400 EE+Spouse \$800 EE+ Child(ren) \$1,200 EE+ Family \$1,200	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> .
Are there services covered before you meet your <u>deductible</u>?	Yes. Services that charge a <u>copayment</u> , <u>prescription drugs</u> , emergency room services, and certain <u>preventive care</u> are covered before you meet your <u>deductible</u> .	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 cost sharing and before you meet your deductible. See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	Yes. Per occurrence: \$250 <u>In-Network</u> inpatient admission. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	For <u>In-Network</u> : EE Only \$2,000 EE+Spouse \$4,000 EE+ Child(ren) \$6,000 EE+ Family \$6,000	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.
What is not included in the <u>out-of-pocket limit</u>?	Premiums, <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> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.bcbstx.com or call 1-800-240-6430 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <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.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$35 <u>copayment</u> /visit; <u>deductible</u> does not apply	Not Covered	Virtual visits are available, please refer to your <u>plan</u> policy for more details.
	<u>Specialist</u> visit	\$50 <u>copayment</u> /visit; <u>deductible</u> does not apply	Not Covered	None
	<u>Preventive care/screening/immunization</u>	No Charge; <u>deductible</u> does not apply	Not Covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	Not Covered	Office visit <u>copayment</u> may apply
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	Not Covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at 855.305.3028	Generic drugs	Preventive Generics Retail: \$10; Mail: \$20 All Other Generics Retail: 15% (\$10 min/ \$50 max); Mail: \$25	Difference between discounted and non-discounted cost PLUS 15% (\$20 min/ \$60 max) <u>coinsurance</u>	Covers up to a 30-day supply (retail), up to 90-day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. Your cost will be higher for choosing Brand over Generics. Maintenance drugs- after two (2) retail fills, members are required to fill a 90-day supply at Mail or CVS Retail Pharmacies, otherwise, higher costs may apply. Preventive medications for designated list of drugs and conditions may bypass <u>deductible</u> and receive applicable cost share noted under "Preventive Drugs." No charge for preferred generic FDA-approved women's contraceptives <u>in-network</u> .
	Preferred brand drugs	Retail: 20% (\$25 min/ \$100 max) Mail: \$68	Difference between discounted and non-discounted cost PLUS 20% (\$50 min/ \$125 max) <u>coinsurance</u>	
	Non-preferred brand drugs	Retail: 30% (\$50min/ \$200 max) Mail: \$125	Difference between discounted and non-discounted cost PLUS 30% (\$100 min/ \$250 max) <u>coinsurance</u>	
	<u>Specialty drugs</u>	\$0 <u>copay</u> if enrolled in PrudentRx; if not enrolled is 30% <u>coinsurance</u>	Difference between discounted and non-discounted cost PLUS 30% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>In-Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	Not Covered	None
	Physician/surgeon fees	10% <u>coinsurance</u>	Not Covered	None
If you need immediate medical attention	<u>Emergency room care</u>	Facility Charges: \$150 <u>copayment</u> /visit plus 10% <u>coinsurance</u> ; <u>deductible</u> does not apply ER Physician Charges: 10% <u>coinsurance</u>	Facility Charges: \$150 <u>copayment</u> /visit plus 10% <u>coinsurance</u> ; <u>deductible</u> does not apply ER Physician Charges: 10% <u>coinsurance</u>	<u>Emergency room copayment</u> waived if admitted.
	<u>Emergency medical transportation</u>	No Charge; <u>deductible</u> does not apply	No Charge; <u>deductible</u> does not apply	Ground and air transportation covered.
	<u>Urgent care</u>	\$75 <u>copayment</u> /visit; <u>deductible</u> does not apply	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> is required. \$250 inpatient admission <u>deductible</u> for <u>In-Network providers</u> .
	Physician/surgeon fees	10% <u>coinsurance</u>	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$35 <u>copayment</u> /office visit; <u>deductible</u> does not apply 10% <u>coinsurance</u> for other outpatient services	Not Covered	Certain services must be preauthorized; refer to your benefit* booklet for details. Virtual visits are available, please refer to your <u>plan</u> policy for more details.
	Inpatient services	10% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> is required. \$250 inpatient admission <u>deductible</u> for <u>In-Network providers</u> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>In-Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you are pregnant	Office visits	\$35 PCP/\$50 SPC <u>copayment/visit</u> ; <u>deductible</u> does not apply	Not Covered	<u>Copayment</u> applies to first prenatal visit (per pregnancy). <u>Cost sharing</u> does not apply for preventive services. 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).
	Childbirth/delivery professional services	10% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> is required. \$250 inpatient admission <u>deductible</u> for <u>In-Network providers</u> .
	Childbirth/delivery facility services	10% <u>coinsurance</u>	Not Covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> is required. Limited to 100 visits per calendar year.
	<u>Rehabilitation services</u>	\$35 PCP/\$50 SPC <u>copayment/visit</u> ; <u>deductible</u> does not apply 10% <u>coinsurance</u> for other outpatient services	Not Covered	Limited to 60 visits combined for all therapies per calendar year. Includes, but is not limited to, occupational, physical, and speech therapy.
	<u>Habilitation services</u>	\$35 PCP/\$50 SPC <u>copayment/visit</u> ; <u>deductible</u> does not apply 10% <u>coinsurance</u> for other outpatient services	Not Covered	
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> is required. Limited to 100 days per calendar year.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	Not Covered	None
	<u>Hospice services</u>	10% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> is required.
If your child needs dental or eye care	Children's eye exam	No Charge; <u>deductible</u> does not apply	Not Covered	1 routine eye exam per calendar year.
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Long term care
- Routine foot care
- Weight loss programs

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

- Acupuncture (lieu of anesthesia)
- Bariatric surgery
- Chiropractic care (Limited to 20 visits maximum per calendar year)
- Dental care (Adult & child)
- Hearing aids (limited to 1 aid per ear per 36-month period, \$3,000 benefit maximum every 36 months)
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (Limited to 70 visits maximum per calendar year)
- Routine eye care (Adult, limited to 1 routine eye exam per calendar year)

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 1-800-240-6430 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 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: For group health coverage subject to ERISA: Blue Cross and Blue Shield of Texas at 1-800-240-6430 or visit www.bcbstx.com, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, and the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or www.tdi.texas.gov. For non-federal governmental group health plans and church plans that are group health plans, Blue Cross and Blue Shield of Texas at 1-800-240-6430 or www.bcbstx.com or contact the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or www.tdi.texas.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Texas Department of Insurance's Consumer Health Assistance Program at 1-800-252-3439 or visit www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/tx.html.

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 1-800-240-6430.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-240-6430.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-240-6430.

Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-240-6430.

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 <u>plan's</u> overall <u>deductible</u>	\$400
■ <u>Specialist</u> copayment	\$50
■ Hospital (facility) both	\$250+10%
■ Other <u>coinsurance</u>	10%

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
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u> *	\$650
<u>Copayments</u>	\$50
<u>Coinsurance</u>	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,960

Managing Joe's type 2 Diabetes

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

The <u>plan's</u> overall <u>deductible</u>	\$400
■ <u>Specialist</u> copayment	\$50
■ Hospital (facility) both	\$250+10%
■ Other <u>coinsurance</u>	10%

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
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$400
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$700
<i>What isn't covered</i>	
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 <u>plan's</u> overall <u>deductible</u>	\$400
■ <u>Specialist</u> copayment	\$50
■ Hospital (facility) both	\$250+10%
■ Other <u>coinsurance</u>	10%

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
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$400
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$60
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$860

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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:	
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

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 مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. 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 Sprachassistentendienste 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 ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઓફિસ/હોમ સહાય અને એક્સેસિબલ ફોર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 855-710-6984 (TTY: 711) પર કોલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.
हिंदी Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 855-710-6984 (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'855-710-6984 (tty: 711) o parla con il tuo fornitore.
한국어 Korean	주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 855-710-6984(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.
Diné Navajo	SHOOH: Diné bee yáníltí'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hólǫ́. Bee ahít hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'í' ahoot'í'ígíí éí t'áá jiik'eh hólǫ́. Kohjí' 855-710-6984 (TTY: 711) hodíilnih doodago nika'análwo'í bich'í' hanidziih.
Farsi فارسی	توجه: اگر فارسی صحبت می کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب های قابل دسترس، به طور رایگان موجود می باشند. با شماره 855-710-6984 (تله تایپ: 711) تماس بگیرید یا با ارائه دهنده 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 serbisyonang 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.
Urdu اردو	توجه 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 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.