



This 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 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 1.855.823.0319. 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 <https://www.healthcare.gov/sbc-glossary> or www.cciio.cms.gov or call 1.855.823.0319 to request a copy.

| Important Questions | Answers | Why this Matters: |
|--|---|---|
| What is the overall deductible? | In-Network \$500 person/ \$1,000 family. Out-of-Network \$3,000 person/ \$6,000 family. | Generally, you must pay all 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 deductible? | Yes. <u>Preventive care</u> services, some <u>prescription drugs</u> , In-Network Routine Vision Care, and Routine Dental Care 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 <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 https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | Yes. Prescription Drug: \$100 <u>deductible</u> at In-Network and Out-of-Network pharmacies only. | 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 out-of-pocket limit for this plan? | In-Network \$9,200 person/ \$15,000 family. Out-of-Network \$15,000 person/ \$30,000 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. |
| What is not included in the out-of-pocket limit? | <u>Premiums</u> , <u>balance-billing</u> charges, chiropractic services, <u>out-of-network copayments</u> 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 network provider? | Yes. See www.SouthCarolinaBlues.com or call 1-800-810-BLUE (2583) 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 <u>plan's 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 referral to see a specialist? | 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 |
|--|--|--|---|--|
| | | <u>In-Network Provider</u> (You will pay the least) | <u>Out-of-Network Provider</u> (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 | \$25 <u>Copay</u> / visit then 20% <u>Coinsurance</u> | \$40 <u>Copay</u> / visit then 30% <u>Coinsurance</u> | None |
| | <u>Specialist</u> visit | \$25 <u>Copay</u> / visit then 20% <u>Coinsurance</u> | \$40 <u>Copay</u> / visit then 30% <u>Coinsurance</u> | None |
| | <u>Preventive care/screening/immunization</u> | No Charge | Not Covered | See www.healthcare.gov for <u>preventive care</u> guidelines. There may be additional benefits available. See your University for details. 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) | \$25 <u>Copay</u> / test then 20% <u>Coinsurance</u> | \$40 <u>Copay</u> / test then 30% <u>Coinsurance</u> | None |
| | Imaging (CT/PET scans, MRIs) | \$150 <u>Copay</u> / test then 20% <u>Coinsurance</u> | \$300 <u>Copay</u> / test then 30% <u>Coinsurance</u> | <u>Pre-authorization</u> is required. Penalty for not obtaining <u>pre-authorization</u> is denial of all charges. |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.SouthCarolinaBlues.com | Generic drugs (Retail) | \$20 <u>Copay</u> / prescription | \$20 <u>Copay</u> / prescription | 90 day supply. <u>Copay</u> applies to each 31 day supply. |
| | Generic drugs (Mail Order) | Not Covered | Not Covered | None |
| | Preferred brand drugs (Retail) | \$40 <u>Copay</u> / prescription | \$40 <u>Copay</u> / prescription | 31 day supply. |
| | Preferred brand drugs (Mail Order) | Not Covered | Not Covered | None |
| | Non-preferred brand drugs (Retail) | \$100 <u>Copay</u> / prescription | \$100 <u>Copay</u> / prescription | 31 day supply. |
| | Non-preferred brand drugs (Mail Order) | Not Covered | Not Covered | None |

| 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) | |
| | <u>Specialty drugs</u> | \$100 <u>Copay</u> / prescription | Not Covered | 31 day supply. Available at an approved Specialty Pharmacy only. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% <u>Coinsurance</u> | 30% <u>Coinsurance</u> | <u>Pre-authorization</u> is required for some outpatient surgeries. Penalty for not obtaining <u>pre-authorization</u> is 50% of the allowable charge. |
| | Physician/surgeon fees | 20% <u>Coinsurance</u> | 30% <u>Coinsurance</u> | None |
| If you need immediate medical attention | <u>Emergency room care</u> | \$200 <u>Copay</u> / visit then 20% <u>Coinsurance</u> | \$200 <u>Copay</u> / visit then 20% <u>Coinsurance</u> | <u>Copayment</u> will be waived if admitted. |
| | <u>Emergency medical transportation</u> | 20% <u>Coinsurance</u> | 20% <u>Coinsurance</u> | None |
| | <u>Urgent care</u> | \$75 <u>Copay</u> / visit then 20% <u>Coinsurance</u> | \$75 <u>Copay</u> / visit then 30% <u>Coinsurance</u> | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% <u>Coinsurance</u> | 30% <u>Coinsurance</u> | <u>Pre-authorization</u> is required. Penalty for not obtaining <u>pre-authorization</u> is denial of room and board. |
| | Physician/surgeon fees | 20% <u>Coinsurance</u> | 30% <u>Coinsurance</u> | None |
| If you need mental health, behavioral health, or substance abuse services | Mental/behavioral health outpatient services | 20% <u>Coinsurance</u> | 30% <u>Coinsurance</u> | <u>Pre-authorization</u> is required. Penalty for not obtaining <u>pre-authorization</u> is 50% of the allowable charge. Office visits are covered at a \$40 <u>copay</u> /visit In-Network; <u>deductible</u> does not apply. Office visits do not require <u>pre-authorization</u> . Out-of-Network office visits are covered at a \$40 <u>copay</u> then 30% <u>Coinsurance</u> /visit. |
| | Substance use disorder outpatient services | 20% <u>Coinsurance</u> | 30% <u>Coinsurance</u> | |
| | Mental/behavioral health inpatient services | 20% <u>Coinsurance</u> | 30% <u>Coinsurance</u> | <u>Pre-authorization</u> is required. Penalty for not obtaining <u>pre-authorization</u> is denial of room and board. |
| | Substance use disorder inpatient services | 20% <u>Coinsurance</u> | 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 are pregnant | Office visits | \$25 <u>Copay</u> / visit then 20% <u>Coinsurance</u> | \$40 <u>Copay</u> / visit then 30% <u>Coinsurance</u> | Pre-authorization for facility services is required. Penalty for not obtaining <u>pre-authorization</u> is denial of room and board. Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. <u>Cost sharing</u> does not apply for <u>preventive services</u> . |
| | Childbirth/delivery professional services | 20% <u>Coinsurance</u> | 30% <u>Coinsurance</u> | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
| | Childbirth/delivery facility services | 20% <u>Coinsurance</u> | 30% <u>Coinsurance</u> | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 20% <u>Coinsurance</u> | 30% <u>Coinsurance</u> | 60 visits/benefit year. <u>Pre-authorization</u> is required. Penalty for not obtaining <u>pre-authorization</u> is denial of all charges. |
| | <u>Rehabilitation services</u> | 20% <u>Coinsurance</u> | 30% <u>Coinsurance</u> | 30 combined visits/benefit year for Occupational Therapy & Physical Therapy. 20 visits/benefit year for Speech Therapy. |
| | <u>Habilitation services</u> | 20% <u>Coinsurance</u> | 30% <u>Coinsurance</u> | 30 combined visits/benefit year for Occupational Therapy & Physical Therapy. 20 visits/benefit year for Speech Therapy. |
| | <u>Skilled nursing care</u> | 20% <u>Coinsurance</u> | 30% <u>Coinsurance</u> | 60 days/benefit year. <u>Pre-authorization</u> is required. Penalty for not obtaining <u>pre-authorization</u> is denial of room and board. |
| | <u>Durable medical equipment</u> | \$25 <u>Copay</u> then 20% <u>Coinsurance</u> | \$40 <u>Copay</u> then 30% <u>Coinsurance</u> | Purchase or rentals of \$500 or more require <u>pre-authorization</u> . Penalty for not obtaining <u>pre-authorization</u> is denial of all charges. |
| | <u>Hospice services</u> | 20% <u>Coinsurance</u> | 30% <u>Coinsurance</u> | 6 months/episode. <u>Pre-authorization</u> is required. Penalty for not obtaining <u>pre-authorization</u> is denial of all charges. |
| If your child needs dental or eye care | Children's eye exam | No Charge | No Charge | Limited to one visit/member under the age of 18/benefit year. Routine eye exams for members over age 18 are covered at a \$20 <u>copay</u> /visit. Limited to one visit/member/benefit year. |

| 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) | |
| | Children's glasses | No Charge | No Charge | Limited to one pair of prescribed lenses and frames or a 12 month supply of contact lenses/member under age 18/benefit year. For members over age 18, INN frames are covered at a \$0 <u>copay</u> and are limited to a \$150 allowance. Standard lenses are covered at a \$20 <u>copay</u> . Contacts are covered at a \$0 <u>copay</u> INN up to \$100. |
| | Children's dental check-up | No Charge | No Charge | Limited to two routine oral exams/member/benefit year. |

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.)

- | | | |
|---------------------|-------------------------|------------------------|
| • Acupuncture | • Hearing Aids | • Private-Duty Nursing |
| • Bariatric Surgery | • Infertility Treatment | • Routine Foot Care |
| • Cosmetic Surgery | • Long-Term Care | • 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 (excludes office visit/unattended electrical stimulation) | • Dental Care (Child) | • Routine Eye Care (Adult) |
| • Dental Care (Adult) | • Non-emergency care when traveling outside the U.S. | • Routine Eye Care (Child) |

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 Department of Health and Human Services Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov, the South Carolina State Department of Insurance at 1-800-768-3467 or visit www.doi.sc.gov. 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: 1.855.823.0319 or visit us at www.SouthCarolinaBlues.com, the South Carolina State Department of Insurance at 1-800-768-3467 or visit www.doi.sc.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 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](#).

—————*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next page.*—————

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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** \$500
- **Specialist Coinsurance** 20%
- **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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| <u>Deductibles*</u> | \$500 |
| <u>Copayments</u> | \$10 |
| <u>Coinsurance</u> | \$2,400 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$2,970 |

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

- **The plan's overall deductible** \$500
- **Specialist Coinsurance** 20%
- **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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| <u>Deductibles*</u> | \$500 |
| <u>Copayments</u> | \$600 |
| <u>Coinsurance</u> | \$400 |
| <i>What isn't covered</i> | |
| 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** \$500
- **Specialist Coinsurance** 20%
- **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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| <u>Deductibles*</u> | \$500 |
| <u>Copayments</u> | \$10 |
| <u>Coinsurance</u> | \$500 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,010 |

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: **1.855.823.0319**.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-832-9686 (TTY: 711) or speak to your provider.

Español: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-844-396-0183 (TTY: 711) o hable con su proveedor. (Spanish)

中文: 注意：如果您說[中文]，我們可以為您提供免費語言援助服務，也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-844-396-0188（TTY：711）或與您的提供者討論。（Chinese）

Tiếng Việt: LƯU Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ và dịch vụ bổ sung phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi 1-844-389-4838 (TTY: 711) hoặc trao đổi với nhà cung cấp dịch vụ của quý vị. (Vietnamese)

РУССКИЙ: ВНИМАНИЕ! Если вы говорите на русском языке, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-844-389-4840 (TTY: 711) или обратитесь к своему поставщику услуг. (Russian)

Tagalog: PAALALA: Kung nagsasalita ka ng Tagalog, available ang mga libreng serbisyo ng tulong sa wika para sa iyo. Available rin nang walang bayad ang mga naaangkop na auxiliary na tulong at serbisyo para magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-844-389-4839 (TTY: 711) o makipag-usap sa iyong provider. (Tagalog)

Português do Brasil: ATENÇÃO: Se você fala português, há serviços gratuitos de assistência linguística disponíveis para você. Assistência e serviços auxiliares próprios para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-844-396-0182 (TTY: 711) ou fale com seu provedor. (Portuguese)

Français : NOTE : Si vous parlez français, des services gratuits d'assistance linguistique sont à votre disposition. Des aides et des services auxiliaires appropriés pouvant fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-844-396-0190 (TTY : 711) ou adressez-vous à votre prestataire. (French)

ગુજરાતી: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા છો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય આિકઝવરી સહાય અને એક્સેસિબલ ફોર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-844-641-2898 (TTY: 711) પર કોલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો. (Gujarati)

Deutsch: 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 unter 1-844-396-0191 (TTY: 711) an oder sprechen Sie mit Ihrem Anbieter. (German)

한국어: 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-844-396-0187(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오. (Korean)

العربية: تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-844-396-0189 (خدمة الهاتف النصّي: 711) أو تحدث إلى مقدم الخدمة. (Arabic)

Українська мова: УВАГА! Якщо ви розмовляєте українською мовою, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби й послуги для надання інформації в доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1- 844-641-2897 (TTY: 711) або зверніться до свого постачальника. (Ukrainian)

日本語: 注: 日本語を希望する場合、無料の言語支援サービスをご利用いただけます。アクセシブル(誰でも利用できるよう配慮された)な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-844-396-0185(TTY: 711)までお電話ください。または、ご利用の事業者にお問い合わせください。(Japanese)

ไทย: โปรดทราบ: หากคุณพูดภาษาไทย เรามีบริการความช่วยเหลือด้านแปลภาษาฟรี นอกจากนี้ ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อที่ 1-844-641-2896 (TTY: 711) หรือปรึกษาผู้ให้บริการของคุณ (Thai)

ລາວ: ຄຳທ່ານເວົ້າພາສາລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາຕີ 1-844-641-2895 (TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ. (Lao)

हिंदी: ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए नि:शुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी नि:शुल्क उपलब्ध हैं। 1-844-641-2894 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें। (Hindi)

Diné SHOOH: Diné bee yáníłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiiik'eh ná hóló. Bee ahil 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'i'ígíí éí t'áá jiiik'eh hóló. Kohjí' 1-844-516-6328 (TTY: 711) hodiilnih doodago nika'análwo'í bich'í' hanidziih. (Navajo)

Kiswahili MAKINIKA: Ikiwa wewe huzungumza Kiswahili, msaada na huduma za lugha bila malipo unapatikana kwako. Vifaa vya usaidizi vinavyofaa na huduma bila malipo ili kutoa taarifa katika mifumo inayofikiwa pia inapatikana bila malipo. Piga simu 1-844-465-1726 (TTY: 711) au zungumza na mtoa huduma wako. (Swahili)

አማርኛ ማሰቢያ:- አማርኛ የሚናገሩ ከሆነ፣ የቁንቁ፣ ጋጋፍ አገልግሎት በገንዘብ ደብዳቤዎቻል። ሞረጃን በተደራሽ ቅርጾች ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በገንዘብ ደገኛ ሎ። በስልክ ቁጥር 1-844-465-1592 (TTY: 711) ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ። (Amharic)

Soomaali FIIRO GAAR AH: Haddaad ku hadasho Soomaali, adeegyo kaalmada luuqadda ah oo bilaash ah ayaad heli kartaa. Qalab caawinaad iyo adeegyo oo habboon si loogu bixiyo macluumaadka qaabab la adeegsan karo ayaa sidoo kale bilaa lacag heli karaa. Wac 1-844-465-1724 (TTY: 711) ama la hadal bixiyahaaga. (Somali)

ILOCANO PANANGIKASO: No agsasaoka iti Ilocano, magun-odmo dagiti libre a serbisio ti tulong iti pagsasao. Libre met laeng a magun-odan dagiti maitutop a katulongan ken serbisio a mangipaay iti impormasion kadagiti ma-akses a pormat. Awagan ti 1-800-832-9686 (TTY: 711) wenno makisarita iti mangipapaay kenka. (Ilocano)

नेपाली सावधान: यदि तपाईंनेपाली भाषा बोल्नुहुन्छ भनेतपाईंका लागि दन:शुल्क भादषक सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रिन ननउपयुक्त सहायता र सेवाहरू पदन दनि:शुल्क उपलब्ध छन्। 1-844-465-1722 (TTY: 711) मा फोन नुनहोस्वा आफ्नो प्रिायकसुँ कु रा नुनहोस्। (Nepali)

ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'1-844-396-0184 (TTY: 711) o parla con il tuo fornitore. (Italian)

বাংলা মনোযোগ দিন: যদি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবাদি উপলব্ধ রয়েছে। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিও বিনামূল্যে উপলব্ধ রয়েছে। 1-844-465-1713 (TTY: 711) নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন। (Bengali)

Kreyòl Ayisyen ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nan 1-844-465-1715 (TTY: 711) oswa pale avèk founisè w la. (Haitian Creole)

POLSKI UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-844-396-0186 (TTY: 711) lub porozmawiaj ze swoim dostawcą. (Polish)

తెలుగు సావధానం: మీరు తెలుగు మాట్లాడితే, మీకు ఉచిత భాషా సహాయ సేవలు అందుబాటులో ఉంటాయి. యాక్సెస్ చేయగల ఫార్మాట్‌లలో సమాచారాన్ని అందించడానికి తగిన సహాయక సహాయాలు మరియు సేవలు కూడా ఉచితంగా అందుబాటులో ఉంటాయి. 1-800-832-9686 (TTY: 711)కి కాల్ చేయండి లేదా మీ ప్రావైడర్‌తో మాట్లాడండి. (Telugu)

Lus Hmoob LUS CEEV TSHWJ XEEB: Yog hais tias koj hais Lus Hmoob muaj cov kev pab cuam txhais lus pub dawb rau koj. Cov kev pab thiab cov kev pab cuam ntxiv uas tsim nyog txhawm rau muab lus qhia paub ua cov hom ntaub ntwav uas tuaj yeem nkgag cuag tau rau los kuj yeej tseem muaj pab dawb tsis xam tus nqi dab tsi ib yam nkaus. Hu rau 1-844-465-1717 (TTY: 711) los sis sib tham nrog koj tus kws muab kev saib xyuas kho mob. (Hmong)

ਪੰਜਾਬੀ ਖ਼ਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। ਪਹੁੰਚਯੋਗ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਜਾਣਕਾਰੀ ਪ੍ਰਦਾਨ ਕਰਨ ਲਈ ਢੁਕਵੇਂ ਪੂਰਕ ਸਹਾਇਕ ਸਾਧਨ ਅਤੇ ਸੇਵਾਵਾਂ ਵੀ ਮੁਫ਼ਤ ਵਿੱਚ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। 1-844-465-1723 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ ਜਾਂ ਆਪਣੇ ਪ੍ਰਦਾਤਾ ਨਾਲ ਗੱਲ ਕਰੋ। (Punjabi)

ភាសាខ្មែរស្តម្ភយកចិត្តទុកដាក់: ប្រសិនបើអ្នកនិយាយ *ភាសាខ្មែរ* សេវាកម្មជំនួយភាសាភក្ដីភីតឡែត្រីមាសសម្រាប់អ្នក។ ជំនួយ និងសេវាកម្មដែលជាការជួយដ៏សមរម្យ ក្នុងការផ្តល់ព័ត៌មានភាមទម្រង់ដែលអាចចូលប្រើប្រាស់បាន ក៏អាចរកបានដោយភក្ដីភីតឡែផងដែរ។ ហៅទូរសព្ទទៅ 1-844-465-1721 (TTY: 711) ឬនិយាយទៅកាន់អ្នកផ្តល់សេវារបស់អ្នក។ (Khmer)

فارسی توجه: اگر فارسی صحبت می‌کنید، خدمات رایگان پشتیبانی زبان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات جانبی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 1-844-398-6233 (تلفن: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید. (Farsi)

اردو توجه دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے مفت لسانی اعانت کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔(1-844-465-1725 TTY: 711) پر کل کریں یا اپنے فراہم کنندہ سے بات کریں۔ (Urdu)

אײדיש אכטונג: אויב איר רעדט אידיש, אומזיסטע שפראך הילף סערוויסעס זענען אוועילעבל פאר אײך. פאסיגע אוקוילירי הילף און סערוויסעס צוצושטעלן אינפארמאציע אין צוטריטליכע פארמאטן זענען אויך אוועילעבל פריי פון אפצאל. רופן 1-833-584-1829 (TTY: 711) אייער פראוויידער. (Yiddish)

Deitsch WICHDICH: Wann du Deitsch schwetzscht, kenne mer dich Schprooch-Hilf griege. Mir kenne dich aa differnti Sadde Hilf griege, wasewwer as braucht fer Information griege, unni as es dich ennich eppes koschde zellt. Call 1-833-584-1829 (TTY: 711) uff odder schwetz mit dei Provider. (Pennsylvania Dutch)

Ελληνικά ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες υποστήριξης στη συγκεκριμένη γλώσσα. Διατίθενται δωρεάν κατάλληλα βοηθήματα και υπηρεσίες για παροχή πληροφοριών σε προσβάσιμες μορφές. Καλέστε το 1-844-465-1714 (TTY: 711) ή απευθυνθείτε στον πάροχό σας. (Greek)

Oromoo Afaan Oromoo HUBACHIIISA: Yoo Afaan Oromoo dubbattan ta’e, tajaajilloota gargaarsa afaanii bilisaan isiniif ni kennama. Gargaarsoonni fi tajaajilloonni sirrii ta’an namoota dhagahuufi arguun isaan rakkisuuf odeeffannoo dhangii dhaqqabamaa ta’een kennuunis bilisaan niargamu. Gara 1-800-832-9686 (TTY: 711) tti bilbilaa yookiin qopheessaa keessan haasofsiisaa. (Oromo)

Gagana Samoa FAAALIGA: Afai e te tautala i le Gagana Samoa, o loo maua fua auaunaga lagolago mo gagana. O le a maua fua fo’i mea faalogo, isi faiga tau fesoasoani ma auaunaga talafeagai e tuuina mai ai faamatalaga i auala faigofie ona maua. Vili le 1-800-832-9686 (TTY: 711) pe talanoa i lau fai auaunaga. (Samoan)