



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 1-800-828-3116 or at www.bcbsil.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 deductible? | In-Network: \$1,000 Individual / \$2,000 Family Out-of-Network: \$2,000 Individual / \$6,000 Family | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . |
| Are there services covered before you meet your deductible? | Yes. Certain <u>preventive care</u> , services that charge a <u>copay</u> and emergency room services are covered before you meet your deductible. | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | Yes. \$250 <u>deductible</u> for In-Network hospital admission and \$300 <u>deductible</u> for out-of-Network hospital 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 out-of-pocket limit for this plan? | In-Network: \$3,500 Individual / \$7,000 Family Out-of-Network: \$8,150 Individual / \$20,000 Family <u>Prescription drug expense limit</u> : Same as medical | 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, Pre-Certification penalties 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.bcbsil.com or call 1-800-828-3116 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 |
|--|--|---|--|---|
| | | 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 | \$30 <u>copay</u> /visit; <u>deductible</u> does not apply | 30% <u>coinsurance</u> | Virtual visits: \$10 /visit; <u>deductible</u> does not apply. See your benefit booklet* for details. |
| | <u>Specialist</u> visit | \$40 <u>copay</u> /visit; <u>deductible</u> does not apply | 30% <u>coinsurance</u> | None |
| | <u>Preventive care/screening/immunization</u> | No Charge; <u>deductible</u> does not apply | 30% <u>coinsurance</u> | 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) | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | <u>Preauthorization</u> may be required; see your benefit booklet* for details. |
| | Imaging (CT/PET scans, MRIs) | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | |

| 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 need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at https://www.caremark.com | Generic drugs | Retail: \$10 <u>copay</u> /prescription Mail Order: \$25 <u>copay</u> /prescription | See Limitations, Exceptions & Other Important Information | Retail drugs are covered up to a 30-day supply; Mail order drugs are covered up to a 90-day supply. When a generic is available, but pharmacy dispenses brand-name medication for any reason, you will pay the difference between the brand-name medication and the generic plus the brand copayment. Prior authorization may be required on some prescriptions. Select maintenance medications are covered at 100%. <u>Specialty drugs</u> limited to a 30-day supply. For <u>Out-of-Network drug provider</u> , retail claims will reject at pharmacy. You can submit receipts as a paper claim, which will be reimbursed at the contracted rate less the applicable cost share or deductible. |
| | Preferred brand drugs | Retail: 35% coinsurance/prescription: minimum \$25, maximum \$100 Mail Order: 35% coinsurance / prescription: minimum \$62.50, maximum \$250 | See Limitations, Exceptions & Other Important Information | |
| | Non-preferred brand drugs | Retail: 50% coinsurance / prescription: minimum \$50, maximum \$125 Mail Order: 50% coinsurance / prescription: minimum \$125, maximum \$312.50 | See Limitations, Exceptions & Other Important Information | |
| | <u>Specialty drugs</u> | 20% coinsurance Distributed exclusively by Caremark Specialty. | Not Covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | <u>Preauthorization</u> may be required. |
| | Physician/surgeon fees | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | None |

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com.

| 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 need immediate medical attention | <u>Emergency room care</u> | Facility Charges: \$300 <u>copay</u> /visit; <u>deductible</u> does not apply ER Physician Charges: No Charge; <u>deductible</u> does not apply | Facility Charges: \$300 <u>copay</u> /visit; <u>deductible</u> does not apply ER Physician Charges: No Charge; <u>deductible</u> does not apply | <u>Copay</u> waived if admitted. |
| | <u>Emergency medical transportation</u> | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | <u>Preauthorization</u> may be required for non-emergency transportation; see your benefit booklet* for details. |
| | <u>Urgent care</u> | \$50 <u>copay</u> /visit; <u>deductible</u> does not apply | 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>Preauthorization</u> required. \$250 <u>deductible</u> per admission In-Network providers and \$300 <u>deductible</u> per admission Out-of-Network. \$1,000 penalty if services are not preauthorized. |
| | Physician/surgeon fees | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$30 <u>copay</u> /office visit; <u>deductible</u> does not apply; 20% <u>coinsurance</u> for other outpatient services | 30% <u>coinsurance</u> | PCP <u>copay</u> applies to psychotherapy office visit only. <u>Preauthorization</u> may be required. See your benefit booklet* for details. |
| | Inpatient services | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | <u>Preauthorization</u> required. \$250 <u>deductible</u> per admission In-Network providers and \$300 <u>deductible</u> per admission Out-of-Network. \$1,000 penalty if services are not preauthorized. |
| If you are pregnant | Office visits | \$30 PCP/\$40 SPC <u>copay</u> /visit; <u>deductible</u> does not apply | 30% <u>coinsurance</u> | <u>Copay</u> applies to first prenatal visit (per pregnancy). <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, <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 | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | \$250 <u>deductible</u> per admission In-Network providers and \$300 <u>deductible</u> per admission Out-of-Network. |
| | Childbirth/delivery facility services | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | <u>Preauthorization</u> may be required. |

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com.

| 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 need help recovering or have other special health needs | <u>Rehabilitation services</u> | No Charge; <u>deductible</u> does not apply | 30% <u>coinsurance</u> | Limited to 60 visits per benefit period for occupational therapy, 60 visits per benefit period for speech therapy, and 60 visits per benefit period for physical therapy. <u>Preadeauthorization</u> may be required. |
| | <u>Habilitation services</u> | No Charge; <u>deductible</u> does not apply | 30% <u>coinsurance</u> | |
| | <u>Skilled nursing care</u> | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | <u>Preadeauthorization</u> required. \$250 <u>deductible</u> per admission In-Network providers and \$300 <u>deductible</u> per admission Out-of-Network. \$1,000 penalty if services are not preauthorized. |
| | <u>Durable medical equipment</u> | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | Benefits are limited to items used to serve a medical purpose. <u>Durable Medical Equipment</u> benefits are provided for both purchase and rental equipment (up to the purchase price). <u>Preadeauthorization</u> may be required. |
| | <u>Hospice services</u> | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | <u>Preadeauthorization</u> required. \$250 <u>deductible</u> per admission In-Network providers and \$300 <u>deductible</u> per admission Out-of-Network. \$1,000 penalty if services are not preauthorized. |

| 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 your child needs dental or eye care | Children's eye exam | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | Limited to 1 eye exam every 12 months. |
| | 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.)

- Acupuncture
- Dental care (Adult)
- Long-term care
- Routine foot care (with the exception of person with diagnosis of diabetes)
- 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 (Chiropractic and Osteopathic manipulation limited to 60 visits per calendar year)
- Cosmetic surgery (only for correcting congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases)
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (with the exception of inpatient private duty nursing) (unlimited visits per year)
- Routine eye care (Exam only)

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 1-800-828-3116, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.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 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: Blue Cross and Blue Shield of Illinois at 1-800-828-3116 or visit www.bcbsil.com, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance at (877) 527-9431 or visit <http://insurance.illinois.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 1-800-828-3116.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-828-3116.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-828-3116.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-828-3116.

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 overall deductible</u> | \$1,000 |
| ■ <u>Specialist copayment</u> | \$40 |
| ■ <u>Hospital (facility) coinsurance</u> | 20% |
| ■ <u>Other coinsurance</u> | 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:

| <u>Cost Sharing</u> | |
|-----------------------------------|----------------|
| <u>Deductibles*</u> | \$1,250 |
| <u>Copayments</u> | \$30 |
| <u>Coinsurance</u> | \$2,200 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$3,540 |

Managing Joe's Type 2 Diabetes

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

| | |
|--|---------|
| ■ The <u>plan's overall deductible</u> | \$1,000 |
| ■ <u>Specialist copayment</u> | \$40 |
| ■ <u>Hospital (facility) coinsurance</u> | 20% |
| ■ <u>Other coinsurance</u> | 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:

| <u>Cost Sharing</u> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$1,000 |
| <u>Copayments</u> | \$900 |
| <u>Coinsurance</u> | \$100 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$2,020 |

Mia's Simple Fracture

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

| | |
|--|---------|
| ■ The <u>plan's overall deductible</u> | \$1,000 |
| ■ <u>Specialist copayment</u> | \$40 |
| ■ <u>Hospital (facility) coinsurance</u> | 20% |
| ■ <u>Other coinsurance</u> | 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:

| <u>Cost Sharing</u> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$1,000 |
| <u>Copayments</u> | \$400 |
| <u>Coinsurance</u> | \$70 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,470 |

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



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 Attn: Office of Civil Rights Coordinator 300 E. Randolph St., 35th Floor Chicago, IL 60601 | Phone: 855-664-7270 (voicemail) TTY/TDD: 855-661-6965 Fax: 855-661-6960 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 200 Independence Avenue SW Room 509F, HHH Building Washington, DC 20201 | Phone: 800-368-1019 TTY/TDD: 800-537-7697 Complaint Portal: 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 bcbsil.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.

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|--------------------|--|
| 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 مجانية. اتصل على الرقم 855-710-6984 (TTY: 711) أو تحدث إلى مقدم الخدمة. |



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| 中文 Chinese | 注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 855-710-6984（文本电话：711）或咨询您的服务提供商。 |
| Français French | ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 855-710-6984 (TTY : 711) ou parlez à votre fournisseur. |
| Deutsch German | ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 855-710-6984 (TTY: 711) an oder sprechen Sie mit Ihrem Provider. |
| ગુજરાતી Gujarati | ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મુક્ત ભાષાકીય સહાયતા સેવાઓ તમારી માટે ઉપલબ્ધ છે. ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મુક્ત ભાષાકીય સહાયતા સેવાઓ તમારી માટે ઉપલબ્ધ છે. ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મુક્ત ભાષાકીય સહાયતા સેવાઓ તમારી માટે ઉપલબ્ધ છે. 855-710-6984 (TTY: 711) પર કોલ કરો અથવા તમારા પ્રદાન સાથે વાત કરો. |
| हिन्दी Hindi | ध्यान दें: यदि आप हिन्दी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएं 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 yáñilti'gogo, saad bee aná'awo' bee áka'anida'awo'ít'áá jiik'eh ná hóló. Bee ahíl hane'go bee nida'anishi t'áá ákodaat'éhígíí dóó bee áka'anida'wo'í áko bee baa hane'í bee hadadílyaa bich'í ahoot'i'igíí éí t'áá jiik'eh hóló. Kohjí' 855-710-6984 (TTY: 711) hodíilnih doodago nika'análwo'í bich'í hanidzíih. |
| فارسی ¹ Farsi | توجه: اگر فارسی صحبت می کنید، خدمات پشتیبانی زبان رایگان در دسترس شما فراز دارد. همچنین کمک ها و خدمات پشتیبانی مناسب برای افراد اخلاقیات در قابلیت های قابل دسترسی، به قدر رایگان موجود می باشند. با شماره 855-710-6984 (TTY: 711) تماس بگیرید یا با ازایندھنده 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 serbisyo 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 ² Urdu | توجه: دین: اگر آپ اردو بولتے ہیں، تو آپ کے لئے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسانی فارمیٹس میں معلومات فراہم کرنے کے لئے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ 855-710-6984 (TTY: 711) پر کال کریں یا اپنے فراہم کرننے کے لئے بات کریں۔ |
| Việt Vietnamese | LUU 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. |