



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 1-800-760-9290. 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 1-800-760-9290 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u>?	Tier 1 \$850 person/ \$2,550 family. In-Network \$1,500 person/ \$4,150 family. Out-of-Network \$1,500 person/ \$4,150 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 <u>deductible</u>?	Yes. <u>Preventive care</u> services 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 <u>deductibles</u> for specific services?	Yes. \$200/person for <u>prescription drugs</u> Tier 2 retail 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 <u>out-of-pocket limit</u> for this <u>plan</u>?	Tier 1 \$4,600 person/ \$9,200 family. In-Network \$6,500 person/ \$13,000 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 <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> charges, <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 <u>network provider</u>?	Yes. See www.SouthCarolinaBlues.com or call 1-800-810-BLUE (2583) for a list of <u>network providers</u> .	You pay the least if you use a <u>provider</u> in Tier 1. You pay more if you use a <u>provider</u> in In-Network Provider. 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 <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
		Tier 1 (You will pay the least)	In-Network Provider (You will pay more)	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>Copay</u> / visit; <u>deductible</u> does not apply	\$50 <u>Copay</u> / visit; <u>deductible</u> does not apply	Not Covered	Allergy Injections, dialysis, surgery and second surgical opinion are covered at 20% <u>Coinsurance</u> at Tier 1. Tier 2 allergy Injections are covered at 35% <u>Coinsurance</u> . Tier 2 office visit <u>Copayment</u> only applies to Evaluation and Management procedures all other services are covered at 30% <u>Coinsurance</u> .
	<u>Specialist</u> visit	\$50 <u>Copay</u> / visit; <u>deductible</u> does not apply	30% <u>Coinsurance</u>	Not Covered	Allergy Injection, dialysis, surgery and second surgical opinion are covered at 20% <u>Coinsurance</u> at Tier 1. Tier 1 Office visit Labs are covered at \$35 <u>Copayment</u> ; <u>deductible</u> does not apply. Tier 2 allergy Injections are 35% <u>Coinsurance</u> .
	<u>Preventive care/screening/immunization</u>	No Charge	30% <u>Coinsurance</u> ; <u>deductible</u> does not apply	Not Covered	Mammograms (Starting at age 33),Paps, Routine Physical and PSAs (prostate screening) are limited to one/benefit period. Colonoscopies facility charges are only covered at Tier 1. See www.healthcare.gov for <u>preventive care</u> guidelines. There may be additional benefits available. See your Employer 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)	\$50 <u>Copay</u> / test; <u>deductible</u> does not apply	\$300 <u>Copay</u> / test then 35% <u>Coinsurance</u>	Not Covered	LabCorp labs are covered at \$35 <u>copayment</u> ; <u>deductible</u> does not apply. Tier 1 inpatient, outpatient & office visit X-Ray \$100 <u>copayment</u> ; <u>deductible</u> does not apply.
	Imaging (CT/PET scans, MRIs)	\$200 <u>Copay</u> / test; <u>deductible</u> does not apply	\$300 <u>Copay</u> / test then 35% <u>Coinsurance</u>	Not Covered	Tier 1 inpatient, outpatient & office visit \$200 <u>copayment</u> ; <u>deductible</u> does not apply.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
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)	\$5 <u>Copay</u> /prescription; <u>deductible</u> does not apply	\$15 <u>Copay</u> /prescription	Not Covered	30 day supply. McLeod Pharmacy 31-90 day supply covered at \$10 <u>Copay</u> /prescription; <u>deductible</u> does not apply.
	Generic drugs (Mail Order)	Not Covered	Not Covered	Not Covered	None
	Preferred brand drugs (Retail)	\$35 <u>Copay</u> /prescription; <u>deductible</u> does not apply	\$50 <u>Copay</u> /prescription	Not Covered	30 day supply. McLeod Pharmacy 31-90 day supply covered at \$70 <u>Copay</u> /prescription; <u>deductible</u> does not apply.
	Preferred brand drugs (Mail Order)	Not Covered	Not Covered	Not Covered	None
	Non-preferred brand drugs (Retail)	\$60 <u>Copay</u> /prescription; <u>deductible</u> does not apply	\$80 <u>Copay</u> /prescription	Not Covered	30 day supply. McLeod Pharmacy 31-90 day supply covered at \$120 <u>Copay</u> /prescription; <u>deductible</u> does not apply.
	Non-Preferred brand drugs (Mail Order)	Not Covered	Not Covered	Not Covered	None
	<u>Specialty Drugs</u>	20% <u>Coinsurance</u> , up to a maximum of \$250 <u>Copay</u> /prescription; <u>deductible</u> does apply;	Not Covered	Not Covered	30 day supply. Disease-modifying anti-rheumatic drugs for autoimmune conditions are subject to a \$1,000 <u>Copay</u> /prescription; deductible does not apply. McLeod Pharmacy only unless unavailable, then at an approved specialty pharmacy only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>Coinsurance</u>	\$300 <u>Copay</u> / visit then 35% <u>Coinsurance</u>	Not Covered	None
	Physician/surgeon fees	20% <u>Coinsurance</u>	35% <u>Coinsurance</u>	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$350 <u>Copay</u> / visit then 20% <u>Coinsurance</u>	\$350 <u>Copay</u> / visit then 20% <u>Coinsurance</u>	\$350 <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>	20% <u>Coinsurance</u>	None
	<u>Urgent care</u>	\$50 <u>Copay</u> / visit; <u>deductible</u> does not apply	\$100 <u>Copay</u> / visit; <u>deductible</u> does not apply	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$300 <u>Copay</u> / admission then 20% <u>Coinsurance</u>	\$1600 <u>Copay</u> / admission then 35% <u>Coinsurance</u>	Not Covered	<u>Pre-authorization</u> is required. Penalty for not obtaining <u>pre-authorization</u> is denial of room and board. Tier 1 is limited to 4 admission <u>copays</u> or \$1,200/benefit year.
	Physician/surgeon fees	20% <u>Coinsurance</u>	35% <u>Coinsurance</u>	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Mental/behavioral health outpatient services	20% <u>Coinsurance</u>	\$300 <u>Copay</u> / visit then 35% <u>Coinsurance</u>	Not Covered	Licensed Therapists are covered at \$10 <u>copayment</u> for Tier 1 & \$35 <u>copayment</u> for Tier 2. Psychologists are covered at \$15 <u>Copayment</u> for Tier 1 & \$50 <u>Copayment</u> for Tier 2. Psychiatrists are covered at \$20 <u>Copayment</u> for Tier 1 & \$60 <u>copayment</u> for Tier 2. <u>Copayment</u> amounts applied to office services only & <u>deductible</u> does not apply.
	Substance use disorder outpatient services	20% <u>Coinsurance</u>	\$300 <u>Copay</u> / visit then 35% <u>Coinsurance</u>	Not Covered	
	Mental/behavioral health inpatient services	20% <u>Coinsurance</u>	\$1600 <u>Copay</u> / admission then 35% <u>Coinsurance</u>	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	Substance use disorder inpatient services	20% <u>Coinsurance</u>	\$1600 <u>Copay</u> / admission then 35% <u>Coinsurance</u>	Not Covered	None
If you are pregnant	Office visits	No Charge	\$50 <u>Copay</u> / visit; <u>deductible</u> does not apply	Not Covered	<u>Pre-authorization</u> 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> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	\$500 <u>Copay</u> / admission; <u>deductible</u> does not apply	35% <u>Coinsurance</u>	Not Covered	
	Childbirth/delivery Facility services	No Charge	\$1600 <u>Copay</u> / admission then 35% <u>Coinsurance</u>	Not Covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>Coinsurance</u>	30% <u>Coinsurance</u>	Not Covered	<u>Pre-authorization</u> is required. Penalty for not obtaining <u>pre-authorization</u> is denial of all charges.
	<u>Rehabilitation services</u>	\$35 <u>Copay</u> / visit; <u>deductible</u> does not apply	\$50 <u>Copay</u> / visit then 35% <u>Coinsurance</u>	Not Covered	Occupational, Physical and Speech Therapy limited to a combined 30 visits/benefit year. Limits do not apply to Tier 1.
	<u>Habilitation services</u>	\$35 <u>Copay</u> / visit; <u>deductible</u> does not apply	\$50 <u>Copay</u> / visit then 35% <u>Coinsurance</u>	Not Covered	Occupational, Physical and Speech Therapy limited to a combined 30 visits/benefit year. Limits do not apply to Tier 1.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	<u>Skilled nursing care</u>	\$300 <u>Copay</u> /admission then 20% <u>Coinsurance</u>	\$1600 <u>Copay</u> /admission then 35% <u>Coinsurance</u>	Not Covered	<u>Pre-authorization</u> is required. Penalty for not obtaining <u>pre-authorization</u> is denial of room and board. Tier 1 is limited to 4 admission <u>copays</u> or \$1,200/benefit year.
	<u>Durable medical equipment</u>	20% <u>Coinsurance</u>	20% <u>Coinsurance</u>	Not Covered	Purchase or rentals of \$500 or more require pre-authorization. Penalty for not obtaining pre-authorization is denial of all charges. Breast Pumps are covered at McLeod Resource Center only at No Charge.
	<u>Hospice services</u>	20% <u>Coinsurance</u>	30% <u>Coinsurance</u>	Not Covered	<u>Pre-authorization</u> is required. Penalty for not obtaining Inpatient facility <u>pre-authorization</u> is denial of room and board and denial of all charges for Outpatient.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered	See your Employer for benefit details.
	Children's glasses	Not Covered	Not Covered	Not Covered	See your Employer for benefit details.
	Children's dental check-up	Not Covered	Not Covered	Not Covered	See your Employer for benefit details.

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.)

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|-----------------------|----------------------------|----------------------------|
| • Acupuncture | • Dental Care (Child) | • Routine Eye Care (Child) |
| • Bariatric Surgery | • Hearing Aids | • Routine Foot Care |
| • Chiropractic Care | • Long-Term Care | • Weight Loss Programs |
| • Cosmetic Surgery | • Private-Duty Nursing | |
| • Dental Care (Adult) | • Routine Eye Care (Adult) | |

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

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| • Infertility Treatment | • Non-emergency care when traveling outside the U.S. |
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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 Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa>. 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: 1-800-760-9290 or visit us at www.SouthCarolinaBlues.com, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa>.

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 <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist Coinsurance</u>	30%
■ Hospital (facility) <u>Coinsurance</u>	35%
■ Other <u>Coinsurance</u>	35%

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:

Cost Sharing	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$3,900
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$5,470

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>	\$1,500
■ <u>Specialist Coinsurance</u>	30%
■ Hospital (facility) <u>Coinsurance</u>	35%
■ Other <u>Coinsurance</u>	35%

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:

Cost Sharing	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$1,400
<u>Coinsurance</u>	\$10
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$2,930

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist Coinsurance</u>	30%
■ Hospital (facility) <u>Coinsurance</u>	35%
■ Other <u>Coinsurance</u>	35%

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:

Cost Sharing	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$400
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,910

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: **1-800-760-9290**.

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 ઓફિસરી સહાય અને એક્સિસિબલ ફોર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-844-641-2898 (TTY: 711) પર કૌંચ 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، فستوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات منسبة لتوفير المعلومات بتسقيقات يمكن الوصول إليها مجاًاً. اتصل على الرقم 1-844-396-0189 (خخصة الهاتف النصتي: 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: ຄືນຄຳບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-844-641-2895 (TTY: 711) ຫຼື ສົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ. (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'anida'awo'it'áá jik'eh ná hółó. Bee ahíł hane'go bee nida'anishi t'áá ákodaat'éhigií dóó bee áka'anida'wo'i áko bee baa hane'i bee hadadilyaa bich'i' ahoot'i'igíí éi t'áá jik'eh hółó. Kohjį' 1-844-516-6328 (TTY: 711) hodilniłnih doodago nika'análwo'i bich'i' hanidziłh. (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 ማሳሰቢያ፡ አማርኛ የሚናገሩ ከሆነ፣ የቅንቋ ድጋፍ አገልግሎት በነፃ ይቀርብዎታል። ሞረጃን በተደራሽ ቅርጽ ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። በስልክ ቁጥር 1-844-465-1592 (TTY: 711) ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ። (Amharic)

Soomaali FIRO 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 दनःशुल्क भादषक सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रान ननउपयुक्त सहायता र सेवाहरू पदन दनिःशुल्क उपलब्ध छन्। 1-844-465-1722 (TTY: 711) मा फोन नुनहोस्वा आफ्नो प्रियकसुँ 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। অ্যাাক্সেসযোগ্য 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 ప్రొవైడర్‌తో 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 ntawv uas tuaj yeem nkag 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
ਪਿਆਰ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਰਾਡੇ ਲਈ ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। ਪਹੁੰਚਯੋਗ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਜਾਣਕਾਰੀ ਪ੍ਰਦਾਨ ਕਰਨ ਲਈ ਢੁਕਵੇਂ ਪੁਰਕ ਸਹਾਇਕ ਸਾਧਨ ਅਤੇ ਸੇਵਾਵਾਂ ਵੀ ਮੁਫਤ ਵਿੱਚ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। 1-844-465-1723 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ ਜਾਂ ਆਪਣੇ ਪ੍ਰਦਾਤਾ ਨਾਲ ਗੱਲ ਕਰੋ। (Punjabi)

ភាសាខ្មែរស្រួចយកចិត្តទុកដាក់: ប្រសិនបើអ្នកនិយាយ ភាសាខ្មែរ លោកម្តងៗនឹងជួយភាសាកម្មវិធីស្ត្រីកម្មវិធីសម្រាប់អ្នក។ ផ្សេងៗ និងលោកម្តងៗនឹងជួយការងារផ្សេងៗផងដែរ។ ហៅទូរសព្ទទៅ 1-844-465-1721 (TTY: 711) ឬនិយាយទៅកាន់អ្នកផ្តល់សេវារបស់អ្នក។ (Khmer)

فارسي
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، باطور رایگان موجود می‌باشند. با شماره 1-844-398-6233 (تلفاتیپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید. (Farsi)
اردو
توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے مفت لمسانی اعانت کی خدمات دستیاب ہیں۔ قابل رسائی فرمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمت بھی مفت دستیاب ہیں۔(1-844-465-1725 TTY: 711) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔ (Urdu)

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

Deutsch
WICHDICH: Wann du Deutsch schwetzscht, kenne mer dich Schprooch-Hilf griege. Mir kenne dich aa differnti Sadde Hilf griege, wasewwer as brauchschtf 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 HUBACHIISA: 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)