



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](http://www.cciio.cms.gov) or call 1-800-760-9290 to request a copy.

Important Questions	Answers	Why this Matters:
<u>What is the overall deductible?</u>	In-Network <b>\$2,000</b> person/ <b>\$4,000</b> family. Out-of-Network <b>\$4,000</b> person/ <b>\$8,000</b> 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 policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
<u>Are there services covered before you meet your deductible?</u>	Yes. In-Network <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 preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<u>Are there other deductibles for specific services?</u>	No.	You don't have to meet <u>deductibles</u> for specific services.
<u>What is the out-of-pocket limit for this plan?</u>	In-Network <b>\$5,000</b> person/ <b>\$10,000</b> family. Out-of-Network <b>\$10,000</b> person/ <b>\$20,000</b> 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.
<u>What is not included in the out-of-pocket limit?</u>	<u>Premiums</u> , <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> .
<u>Will you pay less if you use a network provider?</u>	Yes. See <a href="http://www.SouthCarolinaBlues.com">www.SouthCarolinaBlues.com</a> 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 provider for the difference between the provider's 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.
<u>Do you need a referral to see a 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	30% <u>Coinsurance</u>	40% <u>Coinsurance</u>	None
	<u>Specialist</u> visit	30% <u>Coinsurance</u>	40% <u>Coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No Charge	40% <u>Coinsurance</u>	See <a href="http://www.healthcare.gov">www.healthcare.gov</a> for preventive care 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)	30% <u>Coinsurance</u>	40% <u>Coinsurance</u>	None
	<u>Imaging</u> (CT/PET scans, MRIs)	30% <u>Coinsurance</u>	40% <u>Coinsurance</u>	None
If you need drugs to treat your illness or condition	Generic drugs (Retail)	\$10 <u>Copay</u> / prescription	Not Covered	90 day supply. <u>Copay</u> applies to each 31 day supply.
	Generic drugs (Mail Order)	\$20 <u>Copay</u> / prescription	Not Covered	90 day supply.
	Preferred brand drugs (Retail)	\$40 <u>Copay</u> / prescription	Not Covered	31 day supply.
More information about <u>prescription drug coverage</u> is available at <a href="http://www.SouthCarolinaBlues.com">www.SouthCarolinaBlues.com</a>	Preferred brand drugs (Mail Order)	\$80 <u>Copay</u> / prescription	Not Covered	90 day supply.
	Non-preferred brand drugs (Retail)	\$60 <u>Copay</u> / prescription	Not Covered	31 day supply.
	Non-preferred brand drugs (Mail Order)	\$120 <u>Copay</u> / prescription	Not Covered	90 day supply.
	<u>Specialty drugs</u>	\$125 <u>Copay</u> / prescription	Not Covered	31 day supply. Available at approved Specialty Pharmacy only.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>Coinsurance</u>	40% <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	30% <u>Coinsurance</u>	40% <u>Coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	30% <u>Coinsurance</u>	30% <u>Coinsurance</u>	None
	<u>Emergency medical transportation</u>	30% <u>Coinsurance</u>	30% <u>Coinsurance</u>	None
	<u>Urgent care</u>	30% <u>Coinsurance</u>	40% <u>Coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>Coinsurance</u>	40% <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	30% <u>Coinsurance</u>	40% <u>Coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Mental/behavioral health outpatient services	30% <u>Coinsurance</u>	40% <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 do not require <u>pre-authorization</u> .
	Substance use disorder outpatient services	30% <u>Coinsurance</u>	40% <u>Coinsurance</u>	
	Mental/behavioral health inpatient services	30% <u>Coinsurance</u>	40% <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	30% <u>Coinsurance</u>	40% <u>Coinsurance</u>	
If you are pregnant	Office visits	30% <u>Coinsurance</u>	40% <u>Coinsurance</u>	<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> .
	Childbirth/delivery professional services	30% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)

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)	
	Childbirth/delivery facility services	30% <u>Coinsurance</u>	40% <u>Coinsurance</u>	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	30% <u>Coinsurance</u>	40% <u>Coinsurance</u>	100 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>	30% <u>Coinsurance</u>	40% <u>Coinsurance</u>	45 combined visits/benefit year for Occupational Therapy & Physical Therapy. 45 visits/benefit year for Speech Therapy.
	<u>Habilitation services</u>	30% <u>Coinsurance</u>	40% <u>Coinsurance</u>	45 combined visits/benefit year for Occupational Therapy & Physical Therapy. 45 visits/benefit year for Speech Therapy.
	<u>Skilled nursing care</u>	30% <u>Coinsurance</u>	40% <u>Coinsurance</u>	90 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>	30% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Purchase or rentals of \$1,500 or more require <u>pre-authorization</u> . Penalty for not obtaining <u>pre-authorization</u> is denial of all charges. Wigs are limited to 1/benefit year.
	<u>Hospice services</u>	30% <u>Coinsurance</u>	40% <u>Coinsurance</u>	6 months/episode. <u>Pre-authorization</u> is required. Penalty for not obtaining <u>pre-authorization</u> is denial of room and board for In-Network inpatient and denial of all charges for outpatient and Out-of-Network.
<b>If your child needs dental or eye care</b>	Children's eye exam	No Charge	Not Covered	Limited to one visit/12 month period.
	Children's glasses	Not Covered	Not Covered	See your Employer for benefit details.
	Children's dental check-up	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.)

• Acupuncture	• Dental Care (Adult)	• Long-Term Care
• Bariatric Surgery	• Dental Care (Child)	• Routine Foot Care
• Cosmetic Surgery	• Infertility Treatment	• 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 unattended electrical stimulation)	• Non-emergency care when traveling outside the U.S.	• Routine Eye Care (Adult)
• Hearing Aids (Limited to \$2,000/36 months)	• Private-Duty Nursing (when part of an approved Home Health visit)	• 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 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](http://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](http://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](#).

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*—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> <u>overall deductible</u>	\$2,000
■ <u>Specialist</u> <u>Coinsurance</u>	30%
■ <u>Hospital (facility)</u> <u>Coinsurance</u>	30%
■ <u>Other</u> <u>Coinsurance</u>	30%

**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)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

Cost Sharing	
Deductibles	\$2,000
Copayments	\$30
Coinsurance	\$2,970
What isn't covered	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$5,000</b>

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**.

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

■ The <u>plan's</u> <u>overall deductible</u>	\$2,000
■ <u>Specialist</u> <u>Coinsurance</u>	30%
■ <u>Hospital (facility)</u> <u>Coinsurance</u>	30%
■ <u>Other</u> <u>Coinsurance</u>	30%

**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)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

Cost Sharing	
Deductibles	\$2,000
Copayments	\$500
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$2,800</b>

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

■ The <u>plan's</u> <u>overall deductible</u>	\$2,000
■ <u>Specialist</u> <u>Coinsurance</u>	30%
■ <u>Hospital (facility)</u> <u>Coinsurance</u>	30%
■ <u>Other</u> <u>Coinsurance</u>	30%

**This EXAMPLE event includes services like:**

Emergency room care (including medical supplies)  
Diagnostic test (x-ray)  
Durable medical equipment (crutches)  
Rehabilitation services (physical therapy)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

Cost Sharing	
Deductibles	\$2,000
Copayments	\$0
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,200</b>

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 (ТТУ: 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 હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઓક્ઝિજલરી સહાય અને એક્સેસિબ્લ ફોર્મ્સમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-844-641-2898 (TTY: 711) પર કોણ કરો અથવા તમારા પ્રદાન સાથે વાત કરો. (Gujarati)

**Deutsch:** 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 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)

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 (ТТУ: 711) або зверніться до свого постачальника. (Підтримка)

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)

ວາງ: ເຊັ່ນຊາບ: ຖ້າທ່ານລົງທະບຽນ ລາວ, ຈະມີບໍລິການຈ່າຍລົງທະບຽນພາຍຫຼາຍບໍ່ເປັນຄ່າໃຫຍ້ທ່ານ. ມີຄ່ອງຊ່ວຍລົງທະບຽນ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເຫັນກະຕືອນດັ່ງລີ້ມີໃຫຍ້ຂັ້ນນີ້ໃນຮູບແບບທີ່ສາມາດເຂົ້າໃຈໄດ້. ຂົທທາງເມີນ 1-844-641-2895 (TTY: 711) ຫຼື ລົງທະບຽນໃຫຍ້ວິທີການອາຫຼາມ. (Lao)

हिंदी: 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। 1-844-641-2894 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें। (Hindi)

Diné SHOOH: Diné bee yánilti'gogo, saad bee aná'awo' bee áka'anida'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anida'wo'í áko bee baa hane'í bee hadadilyaa bich'í ahoot'i'ígií éí t'áá jiik'eh hóló. Kohii' 1-844-516-6328 (TTY: 711) hodíílhñ doodago níka'aná'wo'í bich'í hanidzíih. (Navajo)

Kiswahili MAKINIKI: 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)

Soomaali FIIRO GAAR AH: Haddaad ku hadasho Soomaali, adeegyo kaalmada luuqadda ah oo bilaash ahayaad 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 impormasian kadagiti ma-akses a pormat. Awagan ti 1-800-832-9686 (TTY: 711) wenco makisarita iti mangipapaay kenka. (Ilocano)

नेपाली सावधान: यदि तपाईंने पाली भाषा बोल्नुहुन्छ भनेतपाईंका लादि दनःशुल्क भाद्रक सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रिय ननउपयुक्त सहायता र सेवाहरू पदन दनःशुल्क उपलब्ध छन्। 1-844-465-1722 (TTY: 711) मा फोन ननहोस्त्वा आफ्नो प्रियकस्से करा ननहोस। (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)

ବାଂଲା

মনোযোগ দিন: যদি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবাদি উপলক্ষ রয়েছে। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিগুলি বিনামূল্যে উপলক্ষ রয়েছে।

Kreyòl Ayisyen ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplamentè apwopriye pou bay enfòrmasyon nan fòma aksesib yo disponib gratis tou. Rele nan 1-844-465-1715 (TTY 711) ouw pale mèl founiye ou. (United Colors)

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. (Dobry)

Page 8

సాధనం: మీరు తెలుగు మాట్లాడితే, మీకు ఉచిత భాషా సహాయ సేవలు అందుబాటులో ఉంటాయి. యాకెస్స్ చేయగల పొర్కులలో సమాచారాన్ని అందించడానికి తగిన సహాయ సహాయలు మరియు సేవలు కూడా ఉన్నిటివిలు ఉన్నాయి. కంటాయి 1-800-822-9686 (TTV: 711) లో వెంపులు చేయాలి. యాకెస్స్ కోర్సులు కూడా ఉన్నాయి (Tutoring).

## Two-Phase

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 meh. (Hmong)

二三

កាសាទីរុមយកចិត្តទុកដាក់ ប្រសិនបើអ្នកនិយាយ កាសាទីទាំងរាងមួយភាសាគិតគិតថ្មីនៃប្រជាជាតិ ដើម្បីរាយការ ដើម្បីរាយការ និងសេវាអ្នកដែលជាការអ្នយីសមារម្បយ ត្រួតការអ្នល់ព័ត៌មានគម្រោងដែលអាចចូលរើលើការប្រើប្រាស់បាន

فارسی  
توضیح: 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، به طور رایگان موجود می‌باشند. با شماره 6233-398-844-1 (تلغایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود متعارف کنید.

אידיש אוניברסיטאות איר רעדט אידיש, אומזיסטער שפראך הילך און טערויסעס צו צוועטלען אינפארמאציע אין צוֹרְטִילִיכָּע פַּרְמָאָטָּן זענען אויך אועוילעבל פריי פָּן אַפְּצָאָל. רופע (YYT) 711 (0584-1829-1) אעדער רעדט מיט איער פראויזער (Yiddish).

Deitsch

WICHDICH: Wann du Deitsch schwetszsch, kenne mer dich Schprooch-Hilf grieye. Mir kenne dich aa differnti Sadde Hilf grieye, wasewwer as brauchscht fer Information grieye, 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 βιοηθήματα και υπηρεσίες για παροχή πληροφοριών σε προσβάσιμες μορφές. Καλέστε το 1-844-465-1714 (ΤΤΥ: 711) ή απευθυνθείτε στον πάροχό σας. (Greek)

Oromoo

Afaan Oromoo HUBACHIISA: Yoo Afaan Oromoo dubbattan ta'e, tajaajilloota gargaarsa afaanii bilisaan isiniif ni kennama. Gargaarsooni fi tajaajillooni 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)