



BlueCross BlueShield of Illinois

Individual Plan Comparison Charts

All Blue Cross and Blue Shield of Illinois plans provide coverage for preventive services and maternity care. Please see your Summary of Benefits and Coverage or visit **bcbsil.com** for more specific information.

Individual Plan Comparison Chart

Participating Provider Coverage Shown¹

All Blue Cross and Blue Shield of Illinois (BCBSIL) plans provide coverage for preventive services and maternity care. Please see your Summary of Benefits and Coverage or visit bcbsil.com for more specific information.

| Bronze | Blue Choice Preferred Bronze PPO SM | | | | |
|---|--|---|---|---|---|
| | 201 | 202 | 302 ² | 502 ² | 601 |
| Individual Deductible³ | \$6,100 | \$4,500 | \$6,350 | \$5,000 | \$7,000 |
| Coinsurance | 50% | 40% | 40% | 50% | 50% |
| Out-of-Pocket Maximum (includes deductible)³ | \$8,700 | \$7,000 | \$7,000 | \$7,050 | \$8,700 |
| Primary Care Office Visit | \$45 copay | 40% | 40% | 50% | 40% |
| Specialist Office Visit | 50% | 40% | 40% | 50% | 50% |
| Mental Illness Treatment and Substance Abuse Rehabilitation Office Visit | 50% | 40% | 40% | 50% | 40% |
| Emergency Room | \$1,000 per occurrence deductible, then 50% | \$1,000 per occurrence deductible, then 40% | \$1,000 per occurrence deductible, then 40% | \$1,000 per occurrence deductible, then 50% | \$1,000 per occurrence deductible, then 50% |
| Urgent Care | \$60 copay | 40% | 40% | 50% | 50% |
| Inpatient Hospital Services | \$850 per occurrence deductible, then 50% | \$850 per occurrence deductible, then 40% | \$850 per occurrence deductible, then 40% | \$850 per occurrence deductible, then 50% | \$850 per occurrence deductible, then 50% |
| Outpatient Hospital Services⁴ | \$600 per occurrence deductible, then 50% | \$600 per occurrence deductible, then 40% | \$600 per occurrence deductible, then 40% | \$600 per occurrence deductible, then 50% | \$600 per occurrence deductible, then 50% |
| Outpatient X-Rays and Diagnostic Imaging⁴ | 50% | 40% | 40% | 50% | 50% |
| Outpatient Imaging (CT/PET Scans/MRIs)⁴ | 50% | 40% | 40% | 50% | 50% |
| Network | Blue Choice Preferred PPO SM | Blue Choice Preferred PPO SM | Blue Choice Preferred PPO SM | Blue Choice Preferred PPO SM | Blue Choice Preferred PPO SM |
| HSA Eligible⁵ | No | Yes | Yes | Yes | No |
| Outpatient Prescription Drugs - Preferred Pharmacy^{6,7} | \$10 / \$20 / 30% / 35% / 45% / 50% | 20% / 25% / 30% / 35% / 45% / 50% | 20% / 25% / 30% / 35% / 45% / 50% | 20% / 25% / 30% / 35% / 45% / 50% | \$10 / \$20 / 30% / 35% / 45% / 50% |
| Outpatient Prescription Drugs - Non-Preferred Pharmacy^{6,7} | \$20 / \$30 / 35% / 40% / 45% / 50% | 25% / 30% / 35% / 40% / 45% / 50% | 25% / 30% / 35% / 40% / 45% / 50% | 25% / 30% / 35% / 40% / 45% / 50% | \$20 / \$30 / 35% / 40% / 45% / 50% |
| Prescription Drug Benefit Utilization Management Programs⁸ | <p>Specialty Pharmacy Program: To be eligible for maximum benefits, specialty medications must be obtained through the preferred Specialty Pharmacy provider.</p> <p>Member Pay the Difference: When you choose a brand name drug over an available generic equivalent, you pay your usual share for the brand plus the difference in cost.</p> <p>Prior Authorization/Step Therapy Requirements: Before you receive coverage for some medications, your doctor may need to obtain authorization from BCBSIL. You may need to meet certain criteria or try more cost-effective drugs first.</p> <p>90-Day Supply: You may receive up to a 90-day supply of covered prescription drugs through home delivery or at select retail pharmacies, depending on your prescription drug benefit.</p> | | | | |

1 Benefits reduced when out-of-network providers are used. This is a summary of benefit highlights only. All benefits shown represent what the member would pay.

2 This plan is not available on the Health Insurance Marketplace in Illinois.

3 The standard deductible and out-of-pocket maximum for this plan are shown. You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Note that copays apply whether or not you have met the deductible.

4 Members may have lower out-of-pocket costs for some services provided by freestanding non-emergency outpatient facilities than the out-of-pocket costs for services provided in a hospital setting. See your Summary of Benefits and Coverage for additional details.

5 As a reminder, a Health Savings Account (HSA) has tax and legal ramifications. Blue Cross and Blue Shield of Illinois does not provide legal or tax advice and nothing herein should be construed as legal or tax advice. These materials, and any tax-related statements in them, are not intended or written to be used, and cannot be used or relied on for the purpose of avoiding tax penalties.

Tax-related statements, if any, may have been written in connection with the promotion or marketing of the transaction(s) or matter(s) addressed by these materials. You should seek advice based on your particular circumstances from an independent tax adviser regarding tax consequences of specific health insurance plans or products.

6 Prescription drug benefit coverage starts after annual medical deductible has been met, not counting copays. Retail stores in the Preferred Pharmacy Network offer members prescription drugs with a lower possible member cost-share amount. Preferred pharmacy pricing is not available with HMO plans.

7 Six prescription drug payment level tiers: Preferred Generic / Non-Preferred Generic / Preferred Brand / Non-Preferred Brand / Preferred Specialty / Non-Preferred Specialty

8 Home delivery is not available for Specialty tier drugs. Specialty tier drugs are limited to a 30-day supply. Coverage limitations may apply to certain medications.



Individual Plan Comparison Chart

Participating Provider Coverage Shown¹

All Blue Cross and Blue Shield of Illinois (BCBSIL) plans provide coverage for preventive services and maternity care. Please see your Summary of Benefits and Coverage or visit bcbsil.com for more specific information.

| Bronze | Blue Precision Bronze HMO SM | Blue FocusCare Bronze SM | BlueCare Direct Bronze SM in Collaboration with Advocate Health Care ^{***} |
|---|---|---|---|
| | 205 [*] | 209 ^{**} | 401 |
| Individual Deductible³ | \$7,400 | \$7,400 | \$7,400 |
| Coinsurance | 50% | 50% | 50% |
| Out-of-Pocket Maximum (includes deductible)³ | \$8,700 | \$8,700 | \$8,700 |
| Primary Care Office Visit | \$65 copay | \$65 copay | \$65 copay |
| Specialist Office Visit | \$105 copay | \$105 copay | \$105 copay |
| Mental Illness Treatment and Substance Abuse Rehabilitation Office Visit | \$65 copay | \$65 copay | \$65 copay |
| Emergency Room | \$1,000 per occurrence deductible, then 50% | \$1,000 per occurrence deductible, then 50% | \$1,000 per occurrence deductible, then 50% |
| Urgent Care | \$105 copay | \$105 copay | \$105 copay |
| Inpatient Hospital Services | \$850 copay per day | \$850 copay per day | \$850 copay per day |
| Outpatient Hospital Services⁴ | \$300 per occurrence deductible, then 50% | \$300 per occurrence deductible, then 50% | \$300 per occurrence deductible, then 50% |
| Outpatient X-Rays and Diagnostic Imaging⁴ | \$150 copay | \$150 copay | \$150 copay |
| Outpatient Imaging (CT/PET Scans/MRIs)⁴ | \$300 copay | \$300 copay | \$300 copay |
| Network | Blue Precision HMO SM | Blue FocusCare SM | BlueCare Direct SM |
| HSA Eligible⁵ | No | No | No |
| Outpatient Prescription Drugs - Preferred Pharmacy^{6,7} | 10% / 15% / 20% / 30% / 40% / 50% | 10% / 15% / 20% / 30% / 40% / 50% | 10% / 15% / 20% / 30% / 40% / 50% |
| Outpatient Prescription Drugs - Non-Preferred Pharmacy^{6,7} | 10% / 15% / 20% / 30% / 40% / 50% | 10% / 15% / 20% / 30% / 40% / 50% | 10% / 15% / 20% / 30% / 40% / 50% |

Specialty Pharmacy Program: To be eligible for maximum benefits, specialty medications must be obtained through the preferred Specialty Pharmacy provider.

Member Pay the Difference: When you choose a brand name drug over an available generic equivalent, you pay your usual share for the brand plus the difference in cost.

Prior Authorization/Step Therapy Requirements: Before you receive coverage for some medications, your doctor may need to obtain authorization from BCBSIL. You may need to meet certain criteria or try more cost-effective drugs first.

90-Day Supply: You may receive up to a 90-day supply of covered prescription drugs through home delivery or at select retail pharmacies, depending on your prescription drug benefit.

Prescription Drug Benefit Utilization Management Programs⁸

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 7 Six prescription drug payment level tiers: Preferred Generic / Non-Preferred Generic / Preferred Brand / Non-Preferred Brand / Preferred Specialty / Non-Preferred Specialty
 8 Home delivery is not available for Specialty tier drugs. Specialty tier drugs are limited to a 30-day supply. Coverage limitations may apply to certain medications.
*** Blue Precision HMOSM plans are available only in the Chicago, Peoria and Rockford metro areas.**
**** Blue FocusCareSM plans are available only in Cook County.**
*****Advocate Health Care is an independently contracted provider.**



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Participating Provider Coverage Shown¹

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| Silver | Blue Precision Silver HMO SM | | Blue FocusCare Silver SM |
|--|--|---|---|
| | 206 [*] | 306 ^{2*} | 210 ^{**} |
| Individual Deductible ³ | \$3,100 | \$3,300 | \$4,200 |
| Coinsurance | 50% | 50% | 30% |
| Out-of-Pocket Maximum (includes deductible) ³ | \$8,700 | \$8,700 | \$8,700 |
| Primary Care Office Visit | \$35 copay | \$30 copay | \$35 copay |
| Specialist Office Visit | \$75 copay | \$30 copay | \$65 copay |
| Mental Illness Treatment and Substance Abuse Rehabilitation Office Visit | \$35 copay | \$30 copay | \$35 copay |
| Emergency Room | \$1,000 per occurrence deductible, then 50% | \$1,000 per occurrence deductible, then 50% | \$1,000 per occurrence deductible, then 30% |
| Urgent Care | \$75 copay | \$30 copay | \$65 copay |
| Inpatient Hospital Services | \$500 per occurrence deductible, then 50% | \$850 per occurrence deductible, then 50% | \$750 per day copay |
| Outpatient Hospital Services ⁴ | 50% | \$600 per occurrence deductible, then 50% | \$300 per occurrence deductible, then 30% |
| Outpatient X-Rays and Diagnostic Imaging ⁴ | \$20 copay | \$35 copay | \$50 copay |
| Outpatient Imaging (CT/PET Scans/MRIs) ⁴ | \$350 copay | \$250 copay | \$250 copay |
| Network | Blue Precision HMO SM | Blue Precision HMO SM | Blue FocusCare SM |
| HSA Eligible ⁵ | No | No | No |
| Outpatient Prescription Drugs - Preferred Pharmacy ^{6,7} | 0% / 10% / 20% / 30% / 40% / 50% | \$10 / \$20 / 30% / 40% / 45% / 50% | 10% / 15% / 20% / 30% / 40% / 50% |
| Outpatient Prescription Drugs - Non-Preferred Pharmacy ^{6,7} | 0% / 10% / 20% / 30% / 40% / 50% | \$10 / \$20 / 30% / 40% / 45% / 50% | 10% / 15% / 20% / 30% / 40% / 50% |
| Prescription Drug Benefit Utilization Management Programs⁸ | <p>Specialty Pharmacy Program: To be eligible for maximum benefits, specialty medications must be obtained through the preferred Specialty Pharmacy provider.</p> <p>Member Pay the Difference: When you choose a brand name drug over an available generic equivalent, you pay your usual share for the brand plus the difference in cost.</p> <p>Prior Authorization/Step Therapy Requirements: Before you receive coverage for some medications, your doctor may need to obtain authorization from BCBSIL. You may need to meet certain criteria or try more cost-effective drugs first.</p> <p>90-Day Supply: You may receive up to a 90-day supply of covered prescription drugs through home delivery or at select retail pharmacies, depending on your prescription drug benefit.</p> | | |

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 8 Home delivery is not available for Specialty tier drugs. Specialty tier drugs are limited to a 30-day supply. Coverage limitations may apply to certain medications.
 * Blue Precision HMOSM plans are available only in the Chicago, Peoria and Rockford metro areas.
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Individual Plan Comparison Chart

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| Silver | Blue Choice Preferred Silver PPO SM | | BlueCare Direct Silver SM in Collaboration with Advocate Health Care ^{***} |
|---|--|---|---|
| | 203 | 303 ² | 212 |
| Individual Deductible³ | \$2,350 | \$2,350 | \$3,200 |
| Coinsurance | 50% | 50% | 50% |
| Out-of-Pocket Maximum (includes deductible)³ | \$8,700 | \$8,700 | \$8,700 |
| Primary Care Office Visit | \$15 copay | \$15 copay | \$40 copay |
| Specialist Office Visit | 50% | 50% | \$65 copay |
| Mental Illness Treatment and Substance Abuse Rehabilitation Office Visit | 50% | 50% | \$40 copay |
| Emergency Room | \$1,000 per occurrence deductible, then 50% | \$1,000 per occurrence deductible, then 50% | \$1,000 per occurrence deductible, then 50% |
| Urgent Care | \$15 copay | \$15 copay | \$65 copay |
| Inpatient Hospital Services | \$850 per occurrence deductible, then 50% | \$850 per occurrence deductible, then 50% | \$500 per occurrence deductible, then 50% |
| Outpatient Hospital Services⁴ | \$600 per occurrence deductible, then 50% | \$600 per occurrence deductible, then 50% | 50% |
| Outpatient X-Rays and Diagnostic Imaging⁴ | 50% | 50% | \$20 copay |
| Outpatient Imaging (CT/PET Scans/MRIs)⁴ | 50% | 50% | \$250 copay |
| Network | Blue Choice Preferred PPO SM | Blue Choice Preferred PPO SM | BlueCare Direct SM |
| HSA Eligible⁵ | No | No | No |
| Outpatient Prescription Drugs - Preferred Pharmacy^{6,7} | \$5 / \$15 / 30% / 35% / 45% / 50% | \$5 / \$15 / 30% / 35% / 45% / 50% | 0% / 10% / 20% / 30% / 40% / 50% |
| Outpatient Prescription Drugs - Non-Preferred Pharmacy^{6,7} | \$10 / \$25 / 35% / 40% / 45% / 50% | \$10 / \$25 / 35% / 40% / 45% / 50% | 0% / 10% / 20% / 30% / 40% / 50% |
| Prescription Drug Benefit Utilization Management Programs⁸ | <p>Specialty Pharmacy Program: To be eligible for maximum benefits, specialty medications must be obtained through the preferred Specialty Pharmacy provider.</p> <p>Member Pay the Difference: When you choose a brand name drug over an available generic equivalent, you pay your usual share for the brand plus the difference in cost.</p> <p>Prior Authorization/Step Therapy Requirements: Before you receive coverage for some medications, your doctor may need to obtain authorization from BCBSIL. You may need to meet certain criteria or try more cost-effective drugs first.</p> <p>90-Day Supply: You may receive up to a 90-day supply of covered prescription drugs through home delivery or at select retail pharmacies, depending on your prescription drug benefit.</p> | | |

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| Gold | Blue Precision Gold HMO SM | Blue Choice Preferred Gold PPO SM | Blue FocusCare Gold SM | BlueCare Direct Gold SM in Collaboration with Advocate Health Care ^{***} |
|--|--|--|---|---|
| | 207* | 204 | 211** | 409 |
| Individual Deductible ² | \$750 | \$750 | \$750 | \$750 |
| Coinsurance | 30% | 30% | 30% | 30% |
| Out-of-Pocket Maximum (includes deductible) ² | \$8,700 | \$8,700 | \$8,700 | \$8,700 |
| Primary Care Office Visit | \$20 copay | \$15 copay | \$20 copay | \$20 copay |
| Specialist Office Visit | \$40 copay | \$50 copay | \$40 copay | \$40 copay |
| Mental Illness Treatment and Substance Abuse Rehabilitation Office Visit | \$20 copay | \$15 copay | \$20 copay | \$20 copay |
| Emergency Room | \$1,000 per occurrence deductible, then 30% | \$1,000 per occurrence deductible, then 30% | \$1,000 per occurrence deductible, then 30% | \$1,000 per occurrence deductible, then 30% |
| Urgent Care | \$40 copay | \$50 copay | \$40 copay | \$40 copay |
| Inpatient Hospital Services | \$750 per day copay | \$850 per occurrence deductible, then 30% | \$750 per day copay | \$750 per day copay |
| Outpatient Surgery ³ | \$300 per occurrence deductible, then 30% | 30% | \$300 per occurrence deductible, then 30% | \$300 per occurrence deductible, then 30% |
| X-Rays and Diagnostic Imaging ³ | \$40 copay | 30% | \$40 copay | \$40 copay |
| Imaging (CT/PET Scans/MRIs) ³ | \$250 copay | 30% | \$250 copay | \$250 copay |
| Network | Blue Precision HMO SM | Blue Choice Preferred PPO SM | Blue FocusCare SM | BlueCare Direct SM |
| HSA Eligible ⁴ | No | No | No | No |
| Outpatient Prescription Drugs - Preferred Pharmacy ^{5,6} | 10% / 15% / 20% / 30% / 40% / 50% | \$0 / \$10 / 20% / 35% / 45% / 50% | 10% / 15% / 20% / 30% / 40% / 50% | 10% / 15% / 20% / 30% / 40% / 50% |
| Outpatient Prescription Drugs - Non-Preferred Pharmacy ^{5,6} | 10% / 15% / 20% / 30% / 40% / 50% | \$10 / \$20 / 30% / 40% / 45% / 50% | 10% / 15% / 20% / 30% / 40% / 50% | 10% / 15% / 20% / 30% / 40% / 50% |
| Prescription Drug Benefit Utilization Management Programs ⁷ | <p>Specialty Pharmacy Program: To be eligible for maximum benefits, specialty medications must be obtained through the preferred Specialty Pharmacy provider.</p> <p>Member Pay the Difference: When you choose a brand name drug over an available generic equivalent, you pay your usual share for the brand plus the difference in cost.</p> <p>Prior Authorization/Step Therapy Requirements: Before you receive coverage for some medications, your doctor may need to obtain authorization from BCBSIL. You may need to meet certain criteria or try more cost-effective drugs first.</p> <p>90-Day Supply: You may receive up to a 90-day supply of covered prescription drugs through home delivery or at select retail pharmacies, depending on your prescription drug benefit.</p> | | | |

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Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability.

To receive language or communication 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, contact us to file a grievance.

Office of Civil Rights Coordinator
1000 Warrenville Rd
4th Floor
Naperville, IL 60563

Phone/TTY/TDD: Call the customer service number
on your member ID card
Fax: 800-279-7419

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Ave SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
Complaint Forms: <http://www.hhs.gov/ocr/office/file/index.html>



If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

| | |
|--------------------------|---|
| Español Spanish | Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984. |
| العربية Arabic | إن كان لديك أو لدى شخص تساعد أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984. |
| 繁體中文 Chinese | 如果您，或您正在協助的對象，對此有疑問，您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員，請撥電話號碼 855-710-6984。 |
| Français French | Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984. |
| Deutsch German | Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an. |
| ગુજરાતી Gujarati | જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવા કોઈ બાજી વ્યક્તિને એસ.બી.એમ. કાયદકમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કોલ કરો. |
| हिंदी Hindi | यदि आपके, या आप जिसको सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में नि:शुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें। |
| Italiano Italian | Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984. |
| 한국어 Korean | 만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오. |
| Diné Navajo | T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóótí'i' t'áá níí'k'e níká a'doolwoł dóó bina'ídíłkidígíí bee níł h odoonih. Ata'dahalne'ígíí bich'í' hodíílnih kwe'é 855-710-6984. |
| فارسی Persian | اگر شما، یا کسی که شما به او کمک می کنید، سوآلی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید. |
| Polski Polish | Jeśli Ty lub osoba, której pomagasz, macie jakiegokolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984. |
| Русский Russian | Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984. |
| Tagalog Tagalog | Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984. |
| اردو Urdu | اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کر رہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔ |
| Tiếng Việt Vietnamese | Nêu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984. |