



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 1-855-639-2258 or at www.bcbsil.com/osf. 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?	OSF Select Network: \$1,000 Individual / \$2,000 Family In-Network: \$2,000 Individual / \$4,000 Family Out-of-Network: \$3,500 Individual / \$7,000 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> , <u>prescription drugs</u> , and emergency room 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 certain <u>preventive services</u> without <u>cost</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?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	OSF Select Network: \$3,250 Individual / \$6,500 Family In-Network: \$5,000 Individual / \$10,000 Family Out-of-Network: \$10,000 Individual / \$20,000 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, 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/osf or call 1-855-639-2258 for a list of <u>network providers</u> .	You pay the least if you use a <u>provider</u> in OSF Select Network. You pay more if you use a <u>provider in-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 charge</u> 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	OSF Select Network Provider (You will pay the Least)	What You Will Pay		Limitations, Exceptions, & Other Important Information
			In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit; <u>deductible</u> does not apply	\$50 <u>copay</u> /visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	Virtual Visits: OSF Select <u>Network Provider</u> : \$15 <u>copay</u> . In <u>Network Provider</u> : \$50 <u>copay</u> . Out of <u>network</u> : 50% of <u>allowed amount</u> after <u>deductible</u> . There is no coverage for any direct sterilization procedures or associated services, contraceptive methods for the purpose of contraception or sterilization, abortion procedures or associated services, gender reassignment surgery or gender confirming surgery, and infertility procedures, treatments, and medications unless such services are in accordance with the Ethical and Religious Directives for Catholic Health Care Services and Prior-Authorization has been obtained from the Claims Administrator. See the OSF Medical Plan Benefits Description for full details.
	<u>Specialist</u> visit	\$55 <u>copay</u> /visit; <u>deductible</u> does not apply	\$80 <u>copay</u> /visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	Virtual Visits: OSF Select <u>Network Provider</u> : \$40 <u>copay</u> . In <u>Network Provider</u> : \$80 <u>copay</u> . Out of <u>network</u> : 50% of <u>allowed amount</u> after <u>deductible</u> . There is no coverage for any direct sterilization procedures or associated services, contraceptive methods for the purpose of contraception or sterilization, abortion procedures or associated services, gender reassignment surgery or gender confirming surgery, and infertility procedures, treatments, and medications unless such services are in accordance with the Ethical and Religious Directives for Catholic Health Care Services and Prior-Authorization has been obtained from the Claims Administrator. See the OSF Medical Plan Benefits Description for full details.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		OSF Select Network Provider (You will pay the Least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	<u>Preventive care/screening/immunization</u>	No Charge; <u>deductible</u> does not apply	No Charge; <u>deductible</u> does not apply	50% <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. There is no coverage for any direct sterilization procedures or associated services, contraceptive methods for the purpose of contraception or sterilization, abortion procedures or associated services, gender reassignment surgery or gender confirming surgery, and infertility procedures, treatments, and medications unless such services are in accordance with the Ethical and Religious Directives for Catholic Health Care Services and Prior-Authorization has been obtained from the Claims Administrator. See the OSF Medical Plan Benefits Description for full details.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	15% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
	Imaging (CT/PET scans, MRIs)	15% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		OSF Select Network Provider (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 <u>prescription drug coverage</u> is available at www.bcbsil.com/osf	Generic drugs	\$15 <u>copay</u> /prescription (30-day) \$30 <u>copay</u> /prescription (90-day); <u>deductible</u> does not apply	\$30 <u>copay</u> /prescription (30-day) \$60 <u>copay</u> /prescription (90-day); <u>deductible</u> does not apply	Not Covered	30-day supply at Retail 90 day-supply at retail or mail order Dispensing limit may apply to certain drugs. Payment of the difference between the cost of a brand name drug and a generic may be required if a generic drug is available.
	Preferred brand drugs	\$30 <u>copay</u> /prescription (30-day) \$60 <u>copay</u> /prescription (90-day); <u>deductible</u> does not apply	\$60 <u>copay</u> /prescription (30-day) \$120 <u>copay</u> /prescription (90-day); <u>deductible</u> does not apply	Not Covered	Certain individual <u>preventive services</u> will be covered with no cost to the member. For a full list of these prescriptions and/or services, please contact Customer Service.
	Non-preferred brand drugs	\$55 <u>copay</u> /prescription (30-day) \$110 <u>copay</u> /prescription (90-day); <u>deductible</u> does not apply	\$90 <u>copay</u> /prescription (30-day) \$180 <u>copay</u> /prescription (90-day); <u>deductible</u> does not apply	Not Covered	The amount you may pay per 30-day supply of covered insulin drug, regardless of quantity or type, shall not exceed \$35, when obtained from a Preferred Participating or Participating Pharmacy. There is no coverage for contraceptive drugs including: pills, fluids, and other devices, unless determined by the Claims Administrator to be used for therapeutic purposes to cure or alleviate a present and serious pathology when a simpler treatment is not available. There is no coverage for opposite gender hormone therapy or cross-sex hormone therapy, unless determined by Claims Administrator to be Medically Necessary for purposes other than gender dysphoria or related diagnoses.
	<u>Specialty drugs</u>	15% <u>coinsurance</u>	15% <u>coinsurance</u>	Not Covered	<u>Specialty drug</u> coverage based on group policy. Prior authorization may be required. Specialty retail limited to a 30-day supply. <u>Specialty drugs</u> must be filled through an OSF specialty pharmacy whenever possible. Accredo specialty pharmacy may be used for drugs the OSF specialty pharmacy cannot obtain or for those who live outside the service area.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		OSF Select Network Provider (You will pay the Least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
	Physician/surgeon fees	15% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
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	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. Non-Emergency Use of Emergency Room is not covered.
	<u>Emergency medical transportation</u>	15% <u>coinsurance</u>	15% <u>coinsurance</u>	15% <u>coinsurance</u>	15% after OSF Select Network deductible.
	<u>Urgent care</u>	\$25 <u>copay</u> /visit; <u>deductible</u> does not apply	\$50 <u>copay</u> /visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	15% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
	Physician/surgeon fees	15% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copay</u> /visit; <u>deductible</u> does not apply	\$25 <u>copay</u> /visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
	Inpatient services	15% <u>coinsurance</u>	15% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		OSF Select Network Provider (You will pay the Least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	\$25 <u>copay</u> /visit; <u>deductible</u> does not apply	\$50 <u>copay</u> /visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <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	15% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	15% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need help recovering or have other special health needs	<u>Home health care</u>	15% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 100 visits per benefit period. <u>Preauthorization</u> may be required.
	<u>Rehabilitation services</u>	15% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 60 visits combined per benefit period for occupational therapy, speech therapy and physical therapy.
	<u>Habilitation services</u>	15% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	15% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 90 days per benefit period. <u>Preauthorization</u> may be required.
	<u>Durable medical equipment</u>	15% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required. Benefits are limited to items used to serve a medical purpose. Durable Medical Equipment benefits are provided for both purchase and rental equipment (up to the purchase price).
	<u>Hospice services</u>	15% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		OSF Select Network Provider (You will pay the Least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	\$25 <u>copay</u> /visit; <u>deductible</u> does not apply	\$50 <u>copay</u> /visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	One vision exam and one refraction exam every 24 months.
	Children's glasses	Not Covered	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	Not Covered	None

Excluded services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
- Acupuncture - Dental care (Adult) - Hearing aids	- Long term care - Non-emergency care when traveling outside the U.S. - Private duty nursing	- 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 <u>plan</u> document.)		
- Bariatric surgery - Chiropractic care (Chiropractic and Osteopathic manipulation limited to 30 visits per calendar year)	Cosmetic surgery (only for correcting congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases)	- Infertility treatment (<u>preauthorization</u> required) - Routine eye care (includes one vision exam and one refraction exam every 24 months)

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 1-855-639-2258, 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 1-855-639-2258 or visit www.bcbsil.com/osf, 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 1-855-639-2258.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-639-2258.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-855-639-2258.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-639-2258.

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 OSF Select Network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,000
■ <u>Specialist</u> copayment	\$55
■ Hospital (facility) <u>coinsurance</u>	15%
■ Other <u>coinsurance</u>	15%

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:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$40
<u>Coinsurance</u>	\$1,700
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,800

Managing Joe's Type 2 Diabetes

(a year of routine OSF Select Network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,000
■ <u>Specialist</u> copayment	\$55
■ Hospital (facility) <u>coinsurance</u>	15%
■ Other <u>coinsurance</u>	15%

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:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$900
<u>Copayments</u>	\$900
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,820

Mia's Simple Fracture

(OSF Select Network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,000
■ <u>Specialist</u> copayment	\$55
■ Hospital (facility) <u>coinsurance</u>	15%
■ Other <u>coinsurance</u>	15%

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:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,600



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: civilrightscordinator@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.

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



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者。
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 Sprachassistentendienste 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 મફત ભાષા કીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઓફિસલરી સહાય અને એક્સેસિબલ ફોર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 855-710-6984 (TTY: 711) પર કોલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.
हिंदी Hindi	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। 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: 한국어 를 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 yánilti'gogo, saad bee aná'awo' bee áka'anída'awo'it'áá jiik'eh ná hólǫ. Bee ahil hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'í' ahoot'í'ígíí éí t'áá jiik'eh hólǫ. Kohjǫ' 855-710-6984 (TTY: 711) hodíilnih doodago nika'análwo'í bich'í' hanidziih.
Farsi فارسی	توجه: اگر فارسی صحبت می کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب های قابل دسترس، به طور رایگان موجود می باشند. با شماره 855-710-6984 (تلفن تایپ: 711) تماس بگیرید یا با ارائه دهنده 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 serbisyonang 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.
Urdu اردو	توجه دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ 855-710-6984 (TTY: 711) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔
Việt Vietnamese	LƯU 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.