



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-499-1275 or visit Our website at [www.excellusbcbs.com](http://www.excellusbcbs.com). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-800-499-1275 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	In-Network: \$0 Individual/\$0 Family; Out-of-Network: \$300 Individual/ \$750 Family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes, <a href="#">Preventive Care</a>	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Medical: In-Network: \$5,450 Individual/\$10,900 Family; Out-of-Network: \$8,500 Individual/ \$17,000 Family Pharmacy: \$2,550 Individual/\$5,100 Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Costs for penalties for failure to obtain <a href="#">preauthorization</a> for services, <a href="#">premiums</a> , <a href="#">balance billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.excellusbcbs.com">www.excellusbcbs.com</a> or call 1-800-499-1275 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$35 <a href="#">Copay</a> /visit	20% <a href="#">Coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$50 <a href="#">Copay</a> /visit	20% <a href="#">Coinsurance</a>	
	<a href="#">Preventive care/screening/immunization</a>	Adult Physical: No Charge Adult Immunizations: No Charge Well Child Visit: No Charge	Adult Physical: Not Covered Adult Immunizations: Not Covered Well Child Visit: 20% <a href="#">Coinsurance</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. 1 Exam per year
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	X-Ray: \$50 <a href="#">Copay</a> /visit Blood Work: No Charge	X-Ray: 20% <a href="#">Coinsurance</a> Blood Work: 20% <a href="#">Coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	\$75 <a href="#">Copay</a> /visit	20% <a href="#">Coinsurance</a>	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.OptumRx.com">www.OptumRx.com</a>	Tier 1 (Generic drugs)	Wegman's 30-Day Supply: \$15 Copay Mail Order and Wegman's 90-Day Supply: \$37.50	Retail 30-Day Supply: \$17 Copay Retail after 3 fills (30-day Supply): \$37.50 copay	Pharmacy Benefit Administered by OptumRx: 1-855-209-1300.  No 90-Day Supply at non-Wegman's retail. Higher copays for maintenance medications at non-Wegman's retail pharmacy after 3 fills.  Certain breast cancer risk reducing medications in certain cases, smoking cessation medications for those over 18 for certain duration at no charge and for women, generic oral contraceptives are covered with a copay of \$0.
	Tier 2 (Preferred brand drugs)	Wegman's 30-Day Supply: \$35 Copay Mail Order and Wegman's 90-Day Supply: \$87.50	Retail 30-Day Supply: \$40 Copay Retail after 3 fills (30-day Supply): \$87.50 copay	
	Tier 3 (Non-preferred brand drugs)	Wegman's 30-Day Supply: \$50 Copay Mail Order and Wegman's 90-Day Supply: \$125	Retail 30-Day Supply: \$60 Copay Retail after 3 fills (30-day Supply): \$125 copay	
	<a href="#">Specialty drugs</a>	\$17 - \$60		<a href="#">Specialty drugs</a> must be filled by a Designated Pharmacy
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$140 <a href="#">Copay</a>	20% <a href="#">Coinsurance</a>	None
	Physician/surgeon fees	\$50/surgery <a href="#">Copay</a>	20% <a href="#">Coinsurance</a>	
<b>If you need immediate</b>	<a href="#">Emergency room care</a>	\$140 <a href="#">Copay</a> /visit	\$140 <a href="#">Copay</a> /visit	None
	<a href="#">Emergency medical transportation</a>	No Charge	No Charge <a href="#">Deductible</a> does not apply	None

<b>medical attention</b>	<a href="#">Urgent care</a>	\$55 <a href="#">Copay</a> /visit	20% <a href="#">Coinsurance</a>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$200 <a href="#">Copay</a>	20% <a href="#">Coinsurance</a>	None
	Physician/surgeon fees	No Charge	20% <a href="#">Coinsurance</a>	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$50 <a href="#">Copay</a> /visit	20% <a href="#">Coinsurance</a>	Includes Partial Hospitalization for Outpatient services
	Inpatient services	\$200 <a href="#">Copay</a>	20% <a href="#">Coinsurance</a>	
<b>If you are pregnant</b>	Office visits	No Charge	20% <a href="#">Coinsurance</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> .
	Childbirth/delivery professional services	No Charge	20% <a href="#">Coinsurance</a>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Depending on the type of services, a copayment, coinsurance or deductible may apply.
	Childbirth/delivery facility services	\$200 <a href="#">Copay</a>	20% <a href="#">Coinsurance</a>	

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)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No Charge	20% <a href="#">Coinsurance</a>	<a href="#">Deductible</a> is limited to \$50 Out-of-Network
	<a href="#">Rehabilitation services</a>	\$50 <a href="#">Copay</a> /visit	20% <a href="#">Coinsurance</a>	45 Visits per year limit
	<a href="#">Habilitation services</a>	\$50 <a href="#">Copay</a> /visit	20% <a href="#">Coinsurance</a>	45 Visits per year limit
	<a href="#">Skilled nursing care</a>	\$200 <a href="#">Copay</a>	20% <a href="#">Coinsurance</a>	45 Visits per year limit
	<a href="#">Durable medical equipment</a>	20% <a href="#">Coinsurance</a>	20% <a href="#">Coinsurance</a>	None
	<a href="#">Hospice services</a>	No Charge	20% <a href="#">Coinsurance</a>	Family bereavement counseling limited to 5 Visits per year
<b>If your child needs dental or eye care</b>	Children's eye exam	\$50 <a href="#">Copay</a> /visit	Not Covered	1 Exam per year
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	

#### 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](#).)

- |                     |                        |                        |
|---------------------|------------------------|------------------------|
| • Cosmetic surgery  | • Dental care (Adult)  | • Dental care (Child)  |
| • Long-term care    | • Prescription Drugs   | • Private-duty nursing |
| • Routine foot care | • Weight loss programs |                        |

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

- |                            |                         |  |
|----------------------------|-------------------------|--|
| • Acupuncture              | • Bariatric surgery     | • Chiropractic care                                  |
| • Hearing aids             | • Infertility treatment | • Non-emergency care when traveling outside the U.S. |
| • Routine eye care (Adult) |                         |  |

**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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-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 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: the phone number on Your ID card or [www.excellusbcbcs.com](http://www.excellusbcbcs.com); Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa](http://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa); New York State Department of Financial Services Consumer Assistance Unit at 1-800-342-3736 or [www.dfs.ny.gov](http://www.dfs.ny.gov). Additionally, a consumer assistance program can help you file your [appeal](#). Contact the Consumer Assistance Program at 1-888-614-5400, or e-mail [cha@cssny.org](mailto:cha@cssny.org) or

www.communityhealthadvocates.org. A list of states with Consumer Assistance Programs is available at: <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/consumer-assistance-programs.doc> and [www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants](http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants).

**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](#).

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*—————

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist</a> <a href="#">copayment</a>	\$50
■ Hospital (facility) <a href="#">copayment</a>	\$200
■ Other <a href="#">coinsurance</a>	20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

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

*Cost Sharing*

<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$500
<a href="#">Coinsurance</a>	\$0

*What isn't covered*

Limits or exclusions	\$30
<b>The total Peg would pay is</b>	<b>\$530</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist</a> <a href="#">copayment</a>	\$50
■ Hospital (facility) <a href="#">copayment</a>	\$200
■ Other <a href="#">coinsurance</a>	20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

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

*Cost Sharing*

<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,400
<a href="#">Coinsurance</a>	\$0

*What isn't covered*

Limits or exclusions	\$100
<b>The total Joe would pay is</b>	<b>\$1,500</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist</a> <a href="#">copayment</a>	\$50
■ Hospital (facility) <a href="#">copayment</a>	\$200
■ Other <a href="#">coinsurance</a>	20%

This EXAMPLE event includes services like:

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

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

*Cost Sharing*

<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$390
<a href="#">Coinsurance</a>	\$50

*What isn't covered*

Limits or exclusions	\$10
<b>The total Mia would pay is</b>	<b>\$450</b>



## Notice of Nondiscrimination

Our Health Plan complies with federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability, sexual orientation, gender identity, or sex (consistent with the scope of sex discrimination as described at 45CFR section 92.10(a)(2)). The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sexual orientation, gender identity, or sex.

The Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please refer to the enclosed document for ways to reach us.

If you believe that the Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sexual orientation, gender identity, or sex; you can file a grievance with the Health Plan's Section 1557 Coordinator at:

Advocacy Department  
Attn: Civil Rights Coordinator  
PO Box 4717  
Syracuse, NY 13221  
Email: [Advocacy.Department@excellus.com](mailto:Advocacy.Department@excellus.com)  
Telephone number: 1-800-614-6575  
TTY number: 1-800-662-1220  
Fax: 1-315-671-6656

You can file a grievance in person or by mail or fax. If you need help filing a grievance, the Health Plan's Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

This notice is available at Excellus BlueCross BlueShield's website at: [www.ExcellusBCBS.com](http://www.ExcellusBCBS.com)



<p>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. To access these services, please call us at 1-877-626-9298 (TTY: 1-800-662-1220).</p>
<p>ATENCIÓN: Si habla español, tiene disponible servicios gratuitos de asistencia lingüística. También hay disponible de manera gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Para acceder a estos servicios, llámenos al 1-877-626-9298 (TTY: 1-800-662-1220).</p>
<p>انتباه: إذا كنت تتحدث العربية فإن خدمات مساعدة اللغة المجانية متاحة لك. تتوفر أيضًا المساعدات والخدمات المساعدة المناسبة لتوفير المعلومات بتنسيقات يسهل الوصول إليها مجانًا. للوصول إلى هذه الخدمات، يُرجى الاتصال بنا على الرقم 1-877-626-9298 (الهاتف النصي: 1-800-662-1220).</p>
<p>注意：如果您說中文，我們可以為您提供免費的語言幫助。我們也可以為您免費提供適當的輔助工具和服務，以無障礙格式提供資訊。要獲得這些服務，請撥打 1-877-626-9298（TTY：1-800-662-1220）。</p>
<p>ATTENTION : Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et des services supplémentaires appropriés pour fournir des informations dans des formats accessibles sont aussi disponibles gratuitement. Pour accéder à ces services, veuillez nous appeler au 1 877 626 9298 (TTY [ATS] : 1 800 662 1220).</p>
<p>দু আকষণ: আপিন যিদ বাংলাতে কথ্য বেলন, তাহেল িবনামূেল্য ভাষা সহায়তা পিরেষবা আপনার জন্য উপল। অ্যাে সেযাগ্য ফরম্যােট তথ্য দােনর জন্য উপযু সহায়ক সাহায্য এবং পিরেষবা িল ও িবনামূেল্য উপল। এই পিরেষবা িল অ্যাে স করার জন্য, অনু হ কের আমােদর 1-877-626-9298 (TTY: 1-800-662-1220) ন ের কল ক ন।</p>
<p>ВНИМАНИЕ: Если Вы говорите на русском языке, Вам доступны бесплатные услуги языковой поддержки. Также бесплатно доступны соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах. Чтобы воспользоваться этими услугами, позвоните нам по номеру 1-877-626-9298 (TTY: 1-800-662-1220).</p>
<p>ध्यान दनुहोस्: तपाईं नेपाल बोल्नुहुन्छ भने, िनःशुल्क भाषा सहायता सेवाहरू तपाईंका लागि उपलब्ध छन्। सुलभ ढाँचाहरूमा जानकारी दान गर्न उपयुक्त सहायक सहायताहरू र सेवाहरू पिन िनःशुल्क उपलब्ध छन्। यी सेवाहरू उपयोग गर्न, कृपया हामीलाई 1-877-626-9298 (TTY: 1-800-662-1220) मा फोन गर्नुहोस्।</p>
<p>УВАГА: Якщо Ви говорите українською, Вам доступні безкоштовні послуги мовної підтримки. Відповідні допоміжні засоби та послуги для надання інформації в доступних форматах також надаються безкоштовно. Щоб скористатися цими послугами, зателефонуйте нам за номером: 1-877-626-9298 (TTY [Телетайп]: 1-800-662-1220).</p>

<p>FIIRO-GAAR AH: Haddii aad ku hadashid Soomaali, adeeggyada caawimaada luuqadda oo bilaashka ah ayaad helayso. Agabka caawimaada naafada iyo adeeggyo ku habboon oo lagu bixinaayo macluumaadka qaabab la helo karo ayaa sidoo kale lagu heli karaa bilaa lacag. Si loo helo adeegyadaan, fadlan naga soo wac 1-877-626-9298 (TTY: 1-800-662-1220).</p>
<p>ဟ်သျှ်ဟ်သး- နမူ ကတိအဲကလံးကိဉ်တန်န့်, တ တိစၢမၤစၢကိဉ်တန် တ မၤစၢတ မၤ အကလိအိဉ်လၢနဂီ လၢနမၤန့ အီသ့လီၤ. တ မၤစၢတ န ဟူပီးလီ ဒီး တ မၤစၢတ မၤ လၢအဘဉ်ဘျီးဘဉ်ဒါတဖၣ် ကဟ့ၣ်လီၤ တ ဂ့ တ ကိဉ်တန် လၢကိဉ်တန်လၢတ ဉ်တန်လီၤမၤန့ အီသ့တဖၣ် စ့ ကီး အိဉ်လၢနမၤန့ အီသ့ လၢတလိဉ်ဟ့ၣ်အပူၤဘဉ်န့ၣ်လီၤ. လၢကမၤန့ တ မၤစၢတ မၤတဖၣ်အံၤအဂီ , ဝံသးစူၤ ကိးပုၤဖဲ 1-877-626-9298 (TTY: 1-800-662-1220).</p>
<p>သတိပရန်- သင် ငြိမန်မာ ဝေဠာဆုလိင် ဘာသာစကားအကူအညီ ဝန်ဆောင်မှုများကို သင့်အတွက် အခမဲ့ရရှိ ဖို့ ဝိုင်သည်။ မသန်စွမ်းသူများ အသုံးပြု ဝိုင်သည့် ဝေမာမတ်များဖြင့် အချက်အလက်များ ပံ့ပိုးပေးမိ ဝိုင်သည့် သင့်လျော်သော ဝေထက်ကူပစည်းများ ဝိုင် ဝန်ဆောင်မှုများကိုလည်း အခမဲ့ရ ဝိုင်ပါသည်။ ဤဝန်ဆောင်မှုများကို ရရှိရန် က ဝိုင်တိုဝ်းကို 1-877-626-9298 (TTY- 1-800-662-1220) သို့ ဖုန်းခေါ် ဆိုပါ။</p>
<p>CHÚ : Nếu qu vị nói tiếng Việt, chúng tôi có dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho qu vị. Các dịch vụ và hỗ trợ bổ sung thích hợp để cung cấp thông tin ở các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Để sử dụng các dịch vụ này, vui lòng gọi cho chúng tôi theo số 1-877-626-9298 (TTY: 1-800-662-1220).</p>
<p>ATANSYON: Si ou pale Kreyòl Ayisyen, sèvis asistans lang gratis disponib pou ou. Èd ak sèvis oksilyè apwopriye pou bay enfòmasyon nan fòm aksesib yo disponib tou gratis. Pou jwenn aksè nan sèvis sa yo, tanpri rele nou nan 1-877-626-9298 (TTY: 1-800-662-1220).</p>
<p>توجه: اگر به زبان دری صحبت می کنید، خدمات کمک زبان رایگان برای شما قابل دسترس است. کمک امدادی مناسب و خدمات برای دسترسی به معلومات در فرمت میسر بصورت مجانی ارائه می شود. برای دسترسی به این خدمات، با این شماره ها تماس حاصل کنید (TTY: 1-800-662-1220) 1-877-626-9298</p>
<p>TAHADHARI: Ikiwa unazungumza Kiswahili, huduma za usaidizi wa lugha bila malipo zinapatikana kwa ajili yako. Misaada ya ziada inayofaa na huduma za kutoa habari katika miundo inayofikika zinapatikana pia bila malipo Ili kupata huduma hizi, tafadhali tupigie simu kwa 1-877-626-9298 (TTY: 1-800-662-1220).</p>