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, visit www.bcbsmt.com/mt/documents/bbf/bb/2027/bb_ambcc720_mt_2027.pdf or by calling 1-800-447-7828. 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?	In-Network: $0 Individual/ $0 Family Out-of-Network: $5,000 Individual/ $10,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	No.	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: $12,000 Individual/$24,000 Family Out-of-Network: Unlimited Individual/Unlimited Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbsmt.com/bluepreferred or call 1-800-447-7828 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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	$45 - $70/visit	30% coinsurance	Virtual Visits: $5 copayment/visit. No Charge for first 3 office visits; Copayments apply to subsequent visits. Copayments are shown as a range. The amount you pay is determined by the provider you choose and the service you receive. See your benefit booklet* for details.
	Specialist visit	$75 - $115/visit	30% coinsurance	Copayments are shown as a range. The amount you pay is determined by the provider you choose and the service you receive. See your benefit booklet* for details.
	Preventive care/screening/ immunization	No Charge	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$200 - $400/test	30% coinsurance	Copayments are shown as a range. The amount you pay is determined by the provider you choose and the service you receive. Prior authorization may be required; see your benefit booklet* for details.
	Imaging (CT/PET scans, MRIs)	$100 - $2,000/test	30% coinsurance	

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsmt.com/mt/documents/bbf/bb/2027/bb_ambcc720_mt_2027.pdf.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsmt.com/prescription-drugs/managing-prescriptions/drug-lists	Generic drugs (Preferred)	Retail: Preferred - No Charge Non-Preferred - $10/prescription Mail: No Charge	Retail - $10/prescription; deductible does not apply	Limited to a 30-day supply at retail (or a 90-day supply at a network of select retail pharmacies). Up to a 90-day supply at mail order. Specialty drugs are limited to a 30-day supply except for certain FDA-designated dosing regimens. Payment of the difference between the cost of a brand name drug and a generic drug equivalent may also be required if a generic drug is available. All Out-of-Network prescriptions are subject to a 50% additional charge after the applicable copayment/coinsurance. Additional charge will not apply to any deductible or out-of-pocket amounts. A covered insulin drug will not exceed $25 copayment for a 30-day supply.
	Generic drugs (Non-preferred)	Retail: Preferred - $10/prescription Non-Preferred - $20/prescription Mail: $30/prescription	Retail: $20/prescription; deductible does not apply	
	Brand drugs (Preferred)	Retail: Preferred - $70/prescription Non-Preferred - $90/prescription Mail: $210/prescription	Retail: $90/prescription; deductible does not apply	
	Brand drugs (Non-preferred)	Retail: Preferred – $120/prescription Non-Preferred - $140/prescription Mail: $360/prescription	Retail: $140/prescription; deductible does not apply	
	Specialty drugs (Preferred)	$300/prescription	Retail: $300/prescription; deductible does not apply	
	Specialty drugs (Non-preferred)	$400/prescription	Retail: $400/prescription; deductible does not apply	

*For more information about limitations and exceptions, see the plan or policy document at www.bcbsmt.com/mt/documents/bbf/bb/2027/bb_ambcc720_mt_2027.pdf.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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)	$140 - $3,000/visit	30% coinsurance	Copayments are shown as a range. The amount you pay is determined by the provider you choose and the service you receive. Prior authorization may be required. For Outpatient Infusion Therapy, see your benefit booklet* for details.
	Physician/surgeon fees	No charge	30% coinsurance	Prior authorization may be required. For Outpatient Infusion Therapy, see your benefit booklet* for details.
If you need immediate medical attention	Emergency room care	$900/visit	$900/visit	Copayment waived if admitted. Out of network cost share is subject to Network deductible.
	Emergency medical transportation	$600/trip ground or $600/trip air	$600/trip ground or $600/trip air	None
	Urgent care	$125/visit	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$5,250 - $6,250/stay	30% coinsurance	Copayments are shown as a range. The amount you pay is determined by the provider you choose and the service you receive. Prior authorization required; see your benefit booklet* for details. Failure to obtain prior authorization may result in $500 reduction in benefits.
	Physician/surgeon fees	No charge	30% coinsurance	Prior authorization required. See your benefit booklet* for details.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $45/visit or Outpatient: $200/visit	30% coinsurance	Prior authorization may be required; see your benefit booklet* for details.
	Inpatient services	$5,250/stay	30% coinsurance	Prior authorization required; see your benefit booklet* for details. Failure to obtain prior authorization may result in $500 reduction in benefits.
If you are pregnant	Office visits	Primary Care: $45 - $70/initial visit Specialist: $75 - $115/initial visit	30% coinsurance	Copayments are shown as a range. The amount you pay is determined by the provider you choose and the service you receive. Copayment applies to first prenatal visit only (per pregnancy). Cost sharing does not apply for preventive services. Depending on the
	Childbirth/delivery professional services	No charge	30% coinsurance	

*For more information about limitations and exceptions, see the plan or policy document at www.bcbsmt.com/mt/documents/bbf/bb/2027/bb_ambcc720_mt_2027.pdf.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	$5,250/stay	30% coinsurance	type of services a copayment may apply. Maternity care may include tests and services described elsewhere.
If you need help recovering or have other special health needs	Home health care	$20/occurrence	30% coinsurance	30 visits per benefit period. Failure to obtain prior authorization may result in $500 reduction in benefits. See your benefit booklet* for details.
	Rehabilitation services	$115 - $5,250/day	30% coinsurance	Copayments are shown as a range. The amount you pay is determined by the provider you choose and the service you receive. Outpatient: Separate 25-visit limit per benefit period for Rehabilitation and Habilitation Services, which includes physical, speech, occupational therapy and muscle manipulation. Inpatient: Separate 30-day maximum for Rehabilitation and Habilitation Services per benefit period. Failure to obtain prior authorization may result in $500 reduction in benefits. See your benefit booklet* for details.
	Habilitation services	$115 - $5,250/day	30% coinsurance	
	Skilled nursing care	$5,250/stay	30% coinsurance	30-day inpatient maximum per benefit period. Failure to obtain prior authorization may result in $500 reduction in benefits. See your benefit booklet* for details.
	Durable medical equipment	$50 - $2,000/DME item	30% coinsurance	Medically necessary rental or purchase at the plan's discretion. Durable medical equipment (DME) copayments are listed as a range and vary based on equipment tier. See your benefit booklet* for details.
	Hospice services	Inpatient: $5,250/stay or Home: $100/visit	30% coinsurance	Failure to obtain prior authorization may result in $500 reduction in benefits. See your benefit booklet* for details.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

*For more information about limitations and exceptions, see the plan or policy document at www.bcbsmt.com/mt/documents/bbf/bb/2027/bb_ambcc720_mt_2027.pdf.

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.)

- Abortion (Unless the life of the pregnant individual is endangered)
- Acupuncture
- Cosmetic surgery (With exception of accidental injury repair and some instances for physiological functioning improvement of a malformed body member)
- Dental care (Adult and Child)
- Infertility treatment
- Long-term care
- Routine eye care (Adult and Child)
- Routine foot care (Except for diabetic subscribers)
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care (25 visit maximum per benefit period combined with outpatient therapies)
- Hearing aids (One hearing aid per ear every 48 months)
- Non-emergency care when traveling outside the U.S. (With the exception of any services and supplies provided to a Subscriber incurred outside the United States if the Subscriber traveled to the location for the purposes of receiving medical services, supplies, or drugs)
- Private-duty nursing (Limited to 85 visits per benefit period)

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 1-800-447-7828, 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 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: Blue Cross and Blue Shield of Montana at 1-800-447-7828, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform, or the Montana Commissioner of Securities and Insurance at 1-406-444-2040 or 1-800-332-6148. Additionally, a consumer assistance program can help you file your appeal. Contact the Montana Consumer Assistance Program at 1-800-332-6148 or visit www.csi.mt.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.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsmt.com/mt/documents/bbf/bb/2027/bb_ambcc720_mt_2027.pdf.

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 1-800-447-7828.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-447-7828.
Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-447-7828.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-447-7828.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-800-447-7828 uff.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-447-7828.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-447-7828.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-800-447-7828.

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 plan's overall deductible	**$0**
Specialist copayment	**$75**
Hospital (facility) copayment	**$5,250**
Other	**$0**

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**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$5,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,360**

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

The plan's overall deductible	**$0**
Specialist copayment	**$75**
Hospital (facility) copayment	**$5,250**
Other	**$0**

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**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$1,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,320**

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

The plan's overall deductible	**$0**
Specialist copayment	**$75**
Hospital (facility) copayment	**$5,250**
Other	**$0**

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**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$1,800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,800**

The plan would be responsible for the other costs of these EXAMPLE covered services.

BlueCross BlueShield of Montana

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	Phone:	855-664-7270 (voicemail)
Attn: Office of Civil Rights Coordinator	TTY/TDD:	855-661-6965
300 E. Randolph St., 35th Floor	Fax:	855-661-6960
Chicago, IL 60601	Email:	civilrightscoordinator@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	Phone:	800-368-1019
200 Independence Avenue SW	TTY/TDD:	800-537-7697
Room 509F, HHH Building	Complaint Portal:	
Washington, DC 20201	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 bcbsmt.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.
العربية 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.

Blue Cross and Blue Shield of Montana, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

BlueCross BlueShield of Montana

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商。
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 Sprachassistenzdienste 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 ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 855-710-6984 (TTY: 711) પર કૉલ 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 yáníłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'į' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjį' 855-710-6984 (TTY: 711) hodíilnih doodago nika'análwo'í bich'į' hanidziih.
فارسی Farsi	توجه: اگر فارسی صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 855-710-6984 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده 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 serbisyong 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.
اردو Urdu	توجہ 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 (711:TTY) 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.

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