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/individual/bb/2027/bb_spsh30ppoimtp_mt_2027.pdf or by calling 1-855-258-8471. 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: $3,100 Individual / $6,200 Family Out-of-Network: $12,400 Individual / $24,800 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?	Yes. In-Network Preventive Care services, services with a copayment, some prescription drugs, and In-Network hospice are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. Inpatient Out-of-Network Facility $2,000; Outpatient Surgery Facility Out-of-Network $2,000. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-Network: $10,750 Individual / $21,500 Family Out-of-Network: $43,000 Individual / $86,000 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/bluepreferredppo or call 1-855-258-8471 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	$40/visit; deductible does not apply	50% coinsurance	Virtual Visits: $40/visit. Out-of-state services may require a waiver, see your contract* for details.
	Specialist visit	$100/visit; deductible does not apply	50% coinsurance	Virtual Visits: $100/visit. Out-of-state services may require a waiver, see your contract* for details.
	Preventive care/screening/immunization	No Charge; deductible does not apply	50% 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. Out-of-state services may require a waiver, see your contract* for details.
If you have a test	Diagnostic test (x-ray, blood work)	40% coinsurance	50% coinsurance	Prior Authorization may be required; out-of-state services may require a waiver, see your contract* for details.
	Imaging (CT/PET scans, MRIs)	40% coinsurance	50% coinsurance	Prior Authorization may be required; out-of-state services may require a waiver, see your contract* for details.

*For more information about limitations and exceptions, see the plan or policy document at www.bcbsmt.com/mt/documents/individual/bb/2027/bb_spsh30ppoimtp_mt_2027.pdf

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsmt.com/rx27/6T	Generic drugs (Preferred)	Retail: Value - $5/prescription Participating - $15/prescription Mail: $15/prescription; deductible does not apply	Retail: $15/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 equivalent is available. All Out-of-Network prescriptions are subject to a 50% additional charge after the applicable copay/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. Out-of-state services may require a waiver, see your contract* for details.
	Generic drugs (Non-Preferred)	Retail: Value - $15/prescription Participating - $25/prescription Mail: $45/prescription; deductible does not apply	Retail: $25/prescription; deductible does not apply	
	Brand drugs (Preferred)	Retail: Value - $90/prescription Participating - $115/prescription Mail: $270/prescription; deductible does not apply	Retail: $115/prescription; deductible does not apply	
	Brand drugs (Non-Preferred)	45% coinsurance	Retail: 45% coinsurance	
	Specialty drugs (Preferred)	50% coinsurance	50% coinsurance	
	Specialty drugs (Non-Preferred)	55% coinsurance	55% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	$2,000/visit plus 50% coinsurance	Prior Authorization may be required. For Outpatient Infusion Therapy, out-of-state services may require a waiver, see your contract* for details.
	Physician/surgeon fees	40% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	40% coinsurance	40% coinsurance	None
	Emergency medical transportation	40% coinsurance	40% coinsurance	Prior Authorization may be required for non-emergency transportation; see your contract* for details.
	Urgent care	$60/visit; deductible does not apply	$60/visit; deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	$2,000/visit plus 50% coinsurance	Prior Authorization required. Out-of-state services may require a waiver, see your contract* for details.
	Physician/surgeon fees	40% coinsurance	50% coinsurance	None. Out-of-state services may require a waiver, see your contract* for details.

*For more information about limitations and exceptions, see the plan or policy document at www.bcbsmt.com/mt/documents/individual/bb/2027/bb_spsh30ppoimtp_mt_2027.pdf

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 need mental health, behavioral health, or substance abuse services	Outpatient services	$40/office visit; deductible does not apply 40% coinsurance for other outpatient services	50% coinsurance	Virtual Visits are available. Prior Authorization may be required; out-of-state services may require a waiver, see your contract* for details.
	Inpatient services	40% coinsurance	$2,000/visit plus plan deductible plus 50% coinsurance	Prior Authorization required. Residential treatment facilities will be covered if medical necessity criteria are met. Out-of-state services may require a waiver, see your contract* for details.
If you are pregnant	Office visits	Primary Care: $40/initial visit Specialist: $100/initial visit; deductible does not apply	50% coinsurance	Copayment applies to first prenatal visit (per pregnancy). Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Out-of-state services may require a waiver, see your contract* for details.
	Childbirth/delivery professional services	40% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	40% coinsurance	$2,000/visit plus 50% coinsurance	

*For more information about limitations and exceptions, see the plan or policy document at www.bcbsmt.com/mt/documents/individual/bb/2027/bb_spsh30ppoimtp_mt_2027.pdf

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 need help recovering or have other special health needs	Home health care	40% coinsurance	50% coinsurance	Prior Authorization may be required. 180-visit maximum per benefit period. Out-of-state services may require a waiver, see your contract* for details.
	Rehabilitation services	40% coinsurance	50% coinsurance	Prior Authorization may be required. Includes physical, occupational and speech therapy. Out-of-state services may require a waiver, see your contract* for details.
	Habilitation services	40% coinsurance	50% coinsurance	
	Skilled nursing care	40% coinsurance	50% coinsurance	Prior Authorization may be required. 60-day maximum per benefit period. Out-of-state services may require a waiver, see your contract* for details.
	Durable medical equipment	40% coinsurance	50% coinsurance	Prior Authorization may be required. Out-of-state services may require a waiver, see your contract* for details.
	Hospice services	No Charge; deductible does not apply	Inpatient: $2,000/visit plus plan deductible plus 50% coinsurance Outpatient: 50% coinsurance	Prior Authorization may be required. Out-of-state services may require a waiver, see your contract* for details.
If your child needs dental or eye care	Children's eye exam	No Charge; deductible does not apply	No Charge; deductible does not apply	One exam per benefit period for children under age 19. Out-of-state services may require a waiver, see your contract* for details.
	Children's glasses	40% coinsurance	50% coinsurance	One pair of glasses or one pair of contact lenses per benefit period for children under age 19. Out-of-state services may require a waiver, see your contract* for details.
	Children's dental check-up	Not Covered	Not Covered	None. Out-of-state services may require a waiver, see your contract* for details.

*For more information about limitations and exceptions, see the plan or policy document at www.bcbsmt.com/mt/documents/individual/bb/2027/bb_spsh30ppoimtp_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 (except where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a physician, places the woman in danger of death unless an abortion is performed)
- Bariatric surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Weight loss programs (with the exception of preventive services)

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

- Acupuncture (12-visit maximum per benefit period)
- Chiropractic care (10-visit maximum per benefit period)
- Cosmetic surgery (when medically necessary)
- Hearing aids (for a covered child 18 years of age or younger, limited to 1 item per ear every 3 years or as required by a licensed audiologist)
- Infertility treatment (with the exception of in vitro fertilization and prescription medications)
- Routine foot care (when medically necessary)

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 1-855-258-8471, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact your state insurance department at www.csi.mt.gov/industry/insurance.asp 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 Montana at 1-855-258-8471, 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.

Does this plan meet the Minimum Value Standards? **Not Applicable.**
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 1-855-258-8471.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-258-8471.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-855-258-8471.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-258-8471.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-855-258-8471 uff.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-855-258-8471.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-855-258-8471.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-855-258-8471.

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	$3,100
Specialist copayment	$100
Hospital (facility) coinsurance	40%
Other coinsurance	40%

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	$3,100
Copayments	$50
Coinsurance	$3,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$7,010**

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

The plan's overall deductible	$3,100
Specialist copayment	$100
Hospital (facility) coinsurance	40%
Other coinsurance	40%

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	$900
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,820**

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

The plan's overall deductible	$3,100
Specialist copayment	$100
Hospital (facility) coinsurance	40%
Other coinsurance	40%

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	$2,500
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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:	ocrportal.hhs.gov/ocr/smartscreen/main.jsf
Washington, DC 20201	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

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

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.
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 il 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.
فارسي 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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