BlueCross BlueShield of New Mexico

2027

Individual Plan Comparison Chart

Participating Provider Coverage Shown[1]

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

Bronze	Blue Community Bronze HMO℠		
	201 - Off Exchange HDHP HSA Eligible	202 - Off Exchange HDHP HSA Eligible[2]	603 - Off Exchange HDHP HSA Eligible
Deductible[3]	Individual $8,000 / Family $16,000	Individual $4,750 / Family $9,500	Individual $6,000 / Family $12,000
Coinsurance[4]	Member pays 50%	Member pays 40%	Member pays 50%
Out-of-Pocket Maximum (includes deductible)[3]	Individual $11,300 / Family $22,600	Individual $8,500 / Family $17,000	Individual $10,150 / Family $20,300
Primary Care Office Visit	$40 copay	Member pays 40%	$45 copay
Virtual Visits	$0	Member pays 40%	$0
Specialist Office Visit	$160 copay	Member pays 40%	Member pays 50%
Mental and Behavioral Health/Substance Use Disorder Office Visit	$0	$0 after deductible is met	$0
Emergency Room	After deductible, $750/visit, plus member pays 50%	After deductible, $1,000/visit, plus member pays 40%	After deductible, $1,000/visit, plus member pays 50%
Urgent Care	$80 copay	Member pays 40%	Member pays 50%
Inpatient Hospital Services[5]	After deductible, $850/visit, plus member pays 50%	After deductible, $850/visit, plus member pays 40%	After deductible, $850/visit, plus member pays 50%
Outpatient Surgery[5]	After deductible, $600/visit, plus member pays 50%	After deductible, $600/visit, plus member pays 30%	After deductible, $600/visit, plus member pays 40%
Outpatient X-Rays and Diagnostic Imaging[5]	$300 copay in hospital	Member pays 40% in hospital	Member pays 50% in hospital
Outpatient Imaging (CT/PET Scans/MRIs)[5]	Member pays 50% in hospital	Member pays 40% in hospital	Member pays 50% in hospital
HSA Eligible[6]	Yes	Yes	Yes
Outpatient Prescription Drugs - Preferred Pharmacy[7][8]	$10 / $20 / 30% / 35% / 45% / 50%	20% / 25% / 30% / 35% / 45% / 50%	20% / 25% / 30% / 35% / 45% / 50%
Outpatient Prescription Drugs - Non-Preferred Pharmacy[7][8]	$20 / $30 / 35% / 40% / 45% / 50%	25% / 30% / 35% / 40% / 45% / 50%	25% / 30% / 35% / 40% / 45% / 50%
Prescription Drug Benefit Utilization Management Programs[9]	**Specialty Pharmacy Program:** To be eligible for maximum benefits, specialty medications must be obtained through a preferred Specialty Pharmacy provider. You may be matched to the best-fit specialty pharmacy for your prescription. **Member Pay the Difference:** When you choose a brand name drug over an available generic equivalent, you pay your usual share for the brand plus the difference in cost. **Prior Authorization/Step Therapy Requirements:** Before you receive coverage for some medications, your doctor may need to obtain authorization from BCBSNM. You may need to meet certain criteria or try more cost-effective drugs first. **90-Day Supply:** You may receive up to a 90-day supply of covered prescription drugs through home delivery or at select retail pharmacies, depending on your prescription drug benefit.		

1 Benefits may be reduced when out-of-network providers are used. This is a summary of benefit highlights only.
2 This plan is not available on BeWell, New Mexico's Health Insurance Marketplace.
3 The standard per person deductible and out-of-pocket maximum for this plan are shown. You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Deductibles do not apply to services for which only copays are charged.
4 Coinsurance amounts may be different for certain services. Please see your Summary of Benefits and Coverage for more details.
5 Members may have lower out-of-pocket costs for some services provided by non-emergency freestanding outpatient facilities than the out-of-pocket costs for services provided in a hospital setting. See your Summary of Benefits and Coverage for additional details.
6 As a reminder, a Health Savings Account (HSA) has tax and legal ramifications. Blue Cross and Blue Shield of New Mexico does not provide legal or tax advice, and nothing herein should be construed as legal or tax advice. These materials, and any tax-related statements in them, are not intended or written to be used, and cannot be used or relied on for the purpose of avoiding tax penalties. Tax-related statements, if any, may have been written in connection with the promotion or marketing of the transaction(s) or matter(s) addressed by these materials. You should seek advice based on your particular circumstances from an independent tax adviser regarding tax consequences of specific health insurance plans or products.
7 Prescription drug benefit coverage starts after annual medical deductible has been met, not counting copays. Retail stores in the Preferred Pharmacy Network offer members prescriptions with a lower possible member cost-share amount.
8 Prescription drug payment level tiers: Preferred Generic / Non-Preferred Generic / Preferred Brand / Non-Preferred Brand / Preferred Specialty / Non-Preferred Specialty.
9 Home delivery is not available for Specialty tier drugs. Specialty tier drugs are limited to a 30-day supply in most cases. Coverage limitations may apply to certain medications.

The policies of BCBSNM have exclusions, limitations and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, call BCBSNM at 1-866-445-1396 or contact your independent, authorized broker.

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2027

Individual Plan Comparison Chart

Participating Provider Coverage Shown[1]

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Silver	Blue Community Silver HMO℠			
	203 - Off Exchange	204 - Off Exchange [2]	306 - Off Exchange [2]	308 - Off Exchange
Deductible [3]	Individual $2,500 / Family $5,000	Individual $3,000 / Family $6,000	Individual $1,450 / Family $2,900	Individual $4,750 / Family $9,500
Coinsurance [4]	Member pays 40%	Member pays 40%	Member pays 50%	Member pays 10%
Out-of-Pocket Maximum (includes deductible) [3]	Individual $10,150 / Family $20,300	Individual $11,000 / Family $22,000	Individual $11,000 / Family $22,000	Individual $12,000 / Family $24,000
Primary Care Office Visit	Member pays 30%	$20 copay	Member pays 40%	$70 copay
Virtual Visits	Member pays 30%	$0	Member pays 40%	$0
Specialist Office Visit	Member pays 40%	Member pays 40%	Member pays 50%	$80 copay
Mental and Behavioral Health/Substance Use Disorder Office Visit	$0	$0	$0	$0
Emergency Room	After deductible, $1,000/visit, plus member pays 40%	After deductible, $750/visit, plus member pays 40%	After deductible, $1,000/visit, plus member pays 50%	After deductible, $1,000/visit, plus member pays 10%
Urgent Care	Member pays 40%	$30 copay	Member pays 50%	$60 copay
Inpatient Hospital Services [5]	After deductible, $850/visit, plus member pays 40%	After deductible, $850/visit, plus member pays 40%	After deductible, $850/visit, plus member pays 50%	After deductible, $1,000/visit, plus member pays 10%
Outpatient Surgery [5]	After deductible, $650/visit, plus member pays 40%	After deductible, $600/visit, plus member pays 40%	After deductible, $600/visit, plus member pays 50%	After deductible, $500/visit, plus member pays 10%
X-Rays and Diagnostic Imaging [5]	Member pays 40% in hospital	$200 copay in hospital	Member pays 50% in hospital	Member pays 20%
Imaging (CT/PET Scans/MRIs) [5]	Member pays 40% in hospital	Member pays 40% in hospital	Member pays 50% in hospital	Member pays 10%
HSA Eligible	No	No	No	No
Outpatient Prescription Drugs - Preferred Pharmacy [6] [7]	20% / 25% / 30% / 35% / 45% / 50%	$0 / $15 / 30% / 35% / 45% / 50%	20% / 25% / 30% / 35% / 45% / 50%	$0 / $10 / $50 / 20% / 25% / 30%
Outpatient Prescription Drugs - Non-Preferred Pharmacy [6] [7]	25% / 30% / 35% / 40% / 45% / 50%	$15 / $25 / 35% / 40% / 45% / 50%	25% / 30% / 35% / 40% / 45% / 50%	$10 / $20 / $70 / 20% / 25% / 30%
Prescription Drug Benefit Utilization Management Programs [8]	**Specialty Pharmacy Program:** To be eligible for maximum benefits, specialty medications must be obtained through a preferred Specialty Pharmacy provider. You may be matched to the best-fit specialty pharmacy for your prescription. **Member Pay the Difference:** When you choose a brand name drug over an available generic equivalent, you pay your usual share for the brand plus the difference in cost. **Prior Authorization/Step Therapy Requirements:** Before you receive coverage for some medications, your doctor may need to obtain authorization from BCBSNM. You may need to meet certain criteria or try more cost-effective drugs first. **90-Day Supply:** You may receive up to a 90-day supply of covered prescription drugs through home delivery or at select retail pharmacies, depending on your prescription drug benefit.			

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2 This plan is not available on BeWell, New Mexico's Health Insurance Marketplace.

3 The standard per person deductible and out-of-pocket maximum for this plan are shown. You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Deductibles do not apply to services for which only copays are charged. Based on your income and family status, you may qualify for one of three lower deductible levels. You will be able to see if you qualify and what your premium, deductible and out-of-pocket costs will be before you make a decision to enroll.

4 Coinsurance amounts may be different for certain services. Please see your Summary of Benefits and Coverage for more details.

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

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

7 Prescription drug payment level tiers: Preferred Generic / Non-Preferred Generic / Preferred Brand / Non-Preferred Brand / Preferred Specialty / Non-Preferred Specialty.

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

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Silver	Blue Cross Blue Shield Clear Cost Silver Plan - Off Exchange℠ [2]
Deductible [3]	Individual $6,250 / Family $12,500
Coinsurance [4]	0%
Out-of-Pocket Maximum (includes deductible) [3]	Individual $10,750 / Family $21,500
Primary Care Office Visit	$50 copay
Virtual Visits	$0
Specialist Office Visit	$100 copay
Mental and Behavioral Health/Substance Use Disorder Office Visit	$0
Emergency Room	After deductible, $325 per visit
Urgent Care	$100 copay
Inpatient Hospital Services [5]	After deductible, $300 per visit
Outpatient Surgery [5]	$325 copay
X-Rays and Diagnostic Imaging [5]	$100 copay
Imaging (CT/PET Scans/MRIs) [5]	$100 copay
HSA Eligible	No
Outpatient Prescription Drugs - Preferred Pharmacy [6] [7]	$35 / $50 / $250 / $100 / $250
Outpatient Prescription Drugs - Non-Preferred Pharmacy [6] [7]	$35 / $50 / $250 / $100 / $250
Prescription Drug Benefit Utilization Management Programs [8]	**Specialty Pharmacy Program:** To be eligible for maximum benefits, specialty medications must be obtained through a preferred Specialty Pharmacy provider. You may be matched to the best-fit specialty pharmacy for your prescription. **Member Pay the Difference:** When you choose a brand name drug over an available generic equivalent, you pay your usual share for the brand plus the difference in cost. **Prior Authorization/Step Therapy Requirements:** Before you receive coverage for some medications, your doctor may need to obtain authorization from BCBSNM. You may need to meet certain criteria or try more cost-effective drugs first. **90-Day Supply:** You may receive up to a 90-day supply of covered prescription drugs through home delivery or at select retail pharmacies, depending on your prescription drug benefit.

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4 Coinsurance amounts may be different for certain services. Please see your Summary of Benefits and Coverage for more details.
5 Members may have lower out-of-pocket costs for some services provided by non-emergency freestanding outpatient facilities than the out-of-pocket costs for services provided in a hospital setting. See your Summary of Benefits and Coverage for additional details.
6 Prescription drug benefit coverage starts after annual medical deductible has been met, not counting copays. Retail stores in the Preferred Pharmacy Network offer members prescriptions with a lower possible member cost-share amount.
7 Prescription drug payment level tiers: Generic / Preferred Brand / Non-Preferred Brand / Preferred Specialty / Non-Preferred Specialty.
8 Home delivery is not available for Specialty tier drugs. Specialty tier drugs are limited to a 30-day supply in most cases. Coverage limitations may apply to certain medications.

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2027

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Gold	Blue Community Gold HMO℠			Blue Cross Blue Shield Clear Cost Gold Plan - Off Exchange℠ [2]
	205 - Off Exchange [2]	206 - Off Exchange [2]	705 - Off Exchange [2]	
Deductible [3]	Individual $750 / Family $1,500	Individual $1,000 / Family $2,000	Individual $2,300 / Family $4,600	Individual $3,850 / Family $7,700
Coinsurance [4]	Member pays 20%	Member pays 30%	Member pays 20%	0%
Out-of-Pocket Maximum (includes deductible) [3]	Individual $10,150 / Family $20,300	Individual $10,150 / Family $20,300	Individual $5,750 / Family $11,500	Individual $6,850 / Family $13,700
Primary Care Office Visit	$35 copay	$15 copay	$35 copay	$20 copay
Virtual Visits	No Charge	No Charge	No Charge	No Charge
Specialist Office Visit	$50 copay	$55 copay	$50 copay	$60 copay
Mental and Behavioral Health/Substance Use Disorder Office Visit	$0	$0	$0	$0
Emergency Room	After deductible, $500/visit, plus member pays 20%	After deductible, $1,000/visit, plus member pays 30%	After deductible, $500/visit, plus member pays 30%	After deductible, $150 per visit
Urgent Care	$50 copay	$55 copay	$50 copay	$60 copay
Inpatient Hospital Services [5]	After deductible, $850/visit, plus member pays 20%	After deductible, $850/visit, plus member pays 30%	After deductible, $850/visit, plus member pays 20%	After deductible, $150 per visit
Outpatient Surgery [5]	After deductible, $600/visit, plus member pays 20%	Member pays 30%	After deductible, $600/visit, plus member pays 20%	$125 copay
X-Rays and Diagnostic Imaging [5]	$40 copay in hospital	Member pays 30% in hospital	$40 copay in hospital	$60 copay
Imaging (CT/PET Scans/MRIs) [5]	Member pays 20% in hospital	Member pays 30% in hospital	Member pays 20% in hospital	$60 copay
HSA Eligible	No	No	No	No
Outpatient Prescription Drugs - Preferred Pharmacy [6]	$0 / $10 / 20% / 35% / 45% / 50% [7]	$0 / $10 / 20% / 35% / 45% / 50% [7]	$10 / $20 / 20% / 35% / 45% / 50% [7]	$20 / $30 / $100 / $75 / $190 [8]
Outpatient Prescription Drugs - Non-Preferred Pharmacy [6]	$10 / $20 / 25% / 40% / 45% / 50% [7]	$10 / $20 / 30% / 40% / 45% / 50% [7]	$10 / $20 / 25% / 40% / 45% / 50% [7]	$20 / $30 / $100 / $75 / $190 [8]
Prescription Drug Benefit Utilization Management Programs [9]	**Specialty Pharmacy Program:** To be eligible for maximum benefits, specialty medications must be obtained through a preferred Specialty Pharmacy provider. You may be matched to the best-fit specialty pharmacy for your prescription. **Member Pay the Difference:** When you choose a brand name drug over an available generic equivalent, you pay your usual share for the brand plus the difference in cost. **Prior Authorization/Step Therapy Requirements:** Before you receive coverage for some medications, your doctor may need to obtain authorization from BCBSNM. You may need to meet certain criteria or try more cost-effective drugs first. **90-Day Supply:** You may receive up to a 90-day supply of covered prescription drugs through home delivery or at select retail pharmacies, depending on your prescription drug benefit.			

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4 Coinsurance amounts may be different for certain services. Please see your Summary of Benefits and Coverage for more details.
5 Members may have lower out-of-pocket costs for some services provided by non-emergency freestanding outpatient facilities than the out-of-pocket costs for services provided in a hospital setting. See your Summary of Benefits and Coverage for additional details.
6 Prescription drug benefit coverage starts after annual medical deductible has been met, not counting copays. Retail stores in the Preferred Pharmacy Network offer members prescriptions with a lower possible member cost-share amount.
7 Six prescription drug payment level tiers: Preferred Generic / Non-Preferred Generic / Preferred Brand / Non-Preferred Brand / Preferred Specialty / Non-Preferred Specialty.
8 Five prescription drug payment level tiers: Generic / Preferred Brand / Non-Preferred Brand / Preferred Specialty / Non-Preferred Specialty.
9 Home delivery is not available for Specialty tier drugs. Specialty tier drugs are limited to a 30-day supply in most cases. Coverage limitations may apply to certain medications.

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BlueCross BlueShield of New Mexico

Non-Discrimination Notice

Health Care Coverage Is Important For Everyone

We do not discriminate on the basis of race, religion, 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@hcsc.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 bcbsnm.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.

bcbsnm.com

Blue Cross and Blue Shield of New Mexico, 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 New Mexico

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.
فارسي Farsi	توجه: اگر فارسي 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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