**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.bcbsnm.com/nm/documents/mid-market/benefit-booklets/2026/bb_mnevo07506_nm_2026.pdf or by calling 1-800-432-0750. For 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?** | Preferred provider: $750 Individual / $1,500 Family<br>Non-preferred provider: $1,500 Individual / $3,000 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?** | Yes. Preferred preventive health, prescription drugs, diagnostic services, services with a copayment and mental health services, 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?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | Preferred provider: $3,400 Individual / $10,200 Family<br>Non-preferred provider: $6,800 Individual / $20,400 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 BluePPO Evolution Network at www.bcbsnm.com/blueppo or call 1-800-432-0750 for a list of preferred 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 |
|---|---|---|---|---|
| | | Preferred Provider (You will pay the least) | Non-Preferred 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 | $30/visit; deductible does not apply | 40% coinsurance | Virtual visits: No Charge/Telemedicine: $30/visit; deductible does not apply. No Charge for Covid treatment. You may be subject to additional facility/clinic fees. Please check with your provider. See your benefit booklet* for more details. |
| | Specialist visit | $60/visit; deductible does not apply | 40% coinsurance | No Charge for Covid treatment. You may be subject to additional facility/clinic fees. Please check with your provider. |
| | Preventive care/screening/immunization | No Charge; deductible does not apply | 40% 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. No Charge for Covid vaccines. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No Charge; deductible does not apply | 40% coinsurance | Recommended Clinical Review (RCR) is available. See your benefit booklet* for details. You may be subject to additional facility/clinic fees. Please check with your provider. No Charge for Covid tests. |
| | Imaging (CT/PET scans, MRIs) | $150/test; deductible does not apply | 40% coinsurance | Recommended Clinical Review (RCR) is available. See your benefit booklet* for details. Gynecological or obstetrical ultrasounds do not require prior authorization. You may be subject to additional facility/clinic fees. Please check with your provider. |

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsnm.com/nm/documents/mid-market/benefit-booklets/2026/bb_mnevo07506_nm_2026.pdf.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Preferred Provider (You will pay the least) | Non-Preferred Provider (You will pay the most) | |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.bcbsnm.com/nm/documents/rx-drugs/drug-lists/performance-full-nm-2026.pdf | Generic drugs (Preferred) (Tier 1) | Retail: Preferred - No Charge Participating - $10/prescription Mail: No Charge; deductible does not apply | 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.<br>Payment of the difference between the cost of a brand name drug and a generic may also be required if a generic drug is available.<br>Your cost share for a covered insulin drug will not exceed $25 per 30-day supply at a preferred or participating pharmacy. Certain prescription drugs for the treatment of mental illness, behavioral health, substance abuse disorders and contraceptives will be covered at No Charge to you, when obtained from a participating pharmacy .<br>Third party payments such as drug manufacturer's coupons and rebates apply towards deductible and out-of-pocket limit. |
| | Generic drugs (Non-Preferred) (Tier 2) | Retail: Preferred - $10/prescription Participating - $20/prescription Mail: $30/prescription; deductible does not apply | Retail: $20/prescription; deductible does not apply | |
| | Brand drugs (Preferred) (Tier 3) | Retail: Preferred - $50/prescription Participating - $70/prescription Mail: $150/prescription; deductible does not apply | Retail: $70/prescription; deductible does not apply | |
| | Brand drugs (Non-Preferred) (Tier 4) | Retail: Preferred - $100/prescription Participating - $120/prescription Mail: $300/prescription; deductible does not apply | Retail: $120/prescription; deductible does not apply | |
| | Specialty drugs (Preferred) (Tier 5) | $200/prescription; deductible does not apply | $200/prescription; deductible does not apply | |
| | Specialty drugs (Non-Preferred) (Tier 6) | $300/prescription; deductible does not apply | $300/prescription; deductible does not apply | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance | Recommended Clinical Review (RCR) is available for non-emergency surgery. Outpatient infusion therapy: $100/visit; deductible does not apply. You may be subject to additional facility/clinic fees. Please check with your provider. See your benefit booklet* for details. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | |

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsnm.com/nm/documents/mid-market/benefit-booklets/2026/bb_mnevo07506_nm_2026.pdf.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Preferred Provider (You will pay the least) | Non-Preferred Provider (You will pay the most) | |
| **If you need immediate medical attention** | Emergency room care | $350/visit; deductible does not apply | $350/visit; deductible does not apply | Copayment waived if admitted. Balance billing is not allowed for out-of-network emergency care. No Charge for Covid treatment. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | Recommended Clinical Review (RCR) is available for non-emergency transportation. No Charge for Covid treatment. See your benefit booklet* for details. |
| | Urgent care | $55/visit; deductible does not apply | $55/visit; deductible does not apply | No Charge for Covid treatment. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | Prior authorization may be required, unless for emergency. No Charge for Covid treatment. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | No Charge for Covid treatment. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | No Charge; deductible does not apply | 40% coinsurance | Recommended Clinical Review (RCR) is available. See your benefit booklet* for details. |
| | Inpatient services | No Charge; deductible does not apply | 40% coinsurance | Prior authorization may be required; see your benefit booklet* for details. |

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsnm.com/nm/documents/mid-market/benefit-booklets/2026/bb_mnevo07506_nm_2026.pdf.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Preferred Provider (You will pay the least) | Non-Preferred Provider (You will pay the most) | |
| **If you are pregnant** | Office visits | Primary care: $30/initial visit<br>Specialist: $60/initial visit; deductible does not apply | 40% coinsurance | Copayment charged for initial visit only. Cost sharing does not apply to 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). |
| | Childbirth/delivery professional services | 20% coinsurance | 40% coinsurance | |
| | Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 40% coinsurance | 100 visits/year up to 4-hours per visit. Recommended Clinical Review (RCR) is available. See your benefit booklet* for details. |
| | Rehabilitation services | Physical, occupational, and speech therapies: $30/visit; deductible does not apply, All other Rehabilitation services: 20% coinsurance | 40% coinsurance | Includes physical, occupational, and speech therapies in an office or outpatient setting. You may be subject to additional facility/clinic fees. Please check with your provider. Recommended Clinical Review (RCR) is available. See your benefit booklet* for details. |
| | Habilitation services | Physical, occupational, and speech therapies: $30/visit, deductible does not apply; All other Habilitation services: 20% coinsurance | 40% coinsurance | |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | 60 days per year. Prior authorization may be required for inpatient care; see your benefit booklet* for details. |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | Recommended Clinical Review (RCR) is available. See your benefit booklet* for details. |
| | Hospice services | 20% coinsurance | 40% coinsurance | Inpatient: Prior authorization may be required. Outpatient: Recommended Clinical Review (RCR) is available. See your benefit booklet* for details. |
| **If your child needs dental or eye care** | Children's eye exam | Not Covered | Not Covered | If you purchased vision coverage, see your vision plan information. |
| | Children's glasses | Not Covered | Not Covered | |
| | Children's dental check-up | Not Covered | Not Covered | If you purchased dental coverage, see your dental plan information. |

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsnm.com/nm/documents/mid-market/benefit-booklets/2026/bb_mnevo07506_nm_2026.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.)**

- Cosmetic surgery
- Dental care (Adult, routine dental)
- Infertility treatment (Unless for medical condition causing the infertility)
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (Unless you are diabetic)

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

- Abortion
- Acupuncture (20 visits/year unless for habilitative or rehabilitative purposes)
- Bariatric surgery
- Chiropractic care (20 visits/year unless for habilitative or rehabilitative purposes)
- Hearing aids (For members up to age 21; one hearing aid per ear every 36 months)
- Non-emergency care when traveling outside the U.S.
- Weight loss programs (Only dietary evaluations, and counseling for medical management of morbid obesity and obesity are covered)

**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 1-800-432-0750, 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 or the New Mexico State-Based Exchange BeWell at www.BeWellnm.com. 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 New Mexico (BCBSNM) Appeals Unit at 1-800-432-0750. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the New Mexico Superintendent of Insurance toll-free at 1-855-427-5674 or visit www.osi.state.nm.us.

**Does this plan provide Minimum Essential Coverage?** **Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet the Minimum Value Standards?** **Yes.**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-432-0750.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-432-0750.
Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-432-0750.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-432-0750.

*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 deductibles** | **$750** |
| **Specialist copayment** | **$60** |
| **Hospital (facility) coinsurance** | **20%** |
| **Other coinsurance** | **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)*

| **Total Example Cost** | **$12,700** |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $750 |
| Copayments | $300 |
| Coinsurance | $2,100 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,210** |

### Managing Joe's Type 2 Diabetes

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

| | |
|---|---|
| **The plan's overall deductibles** | **$750** |
| **Specialist copayment** | **$60** |
| **Hospital (facility) coinsurance** | **20%** |
| **Other coinsurance** | **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)*

| **Total Example Cost** | **$5,600** |
|---|---|
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $750 |
| Copayments | $700 |
| Coinsurance | $10 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,480** |

### Mia's Simple Fracture

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

| | |
|---|---|
| **The plan's overall deductibles** | **$750** |
| **Specialist copayment** | **$60** |
| **Hospital (facility) coinsurance** | **20%** |
| **Other coinsurance** | **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)*

| **Total Example Cost** | **$2,800** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $750 |
| Copayments | $800 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,650** |

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

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@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 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<br>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<br>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 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<br>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<br>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<br>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<br>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<br>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<br>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<br>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<br>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<br>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<br>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<br>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<br>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<br>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<br>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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