2027 Summary of Benefits BlueCross Total (PPO)

H8003, Plans 001, 002 and 003

This is a summary of the health and drug services covered by BlueCross Total (PPO): January 1, 2027 – December 31, 2027.

This plan, **BlueCross Total**, is offered by BlueCross BlueShield of South Carolina. **BlueCross Total** is a Medicare Advantage PPO plan with a Medicare contract. Enrollment in BlueCross BlueShield of South Carolina depends on contract renewal.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover, or list every limitation, or exclusion. To get a complete list of services we cover, please request the *Evidence of Coverage* by calling Customer Service at 1-855-204-2744 (TTY users should call 711). The *Evidence of Coverage* is also available online at SCBluesMedAdvantage.com.

To join BlueCross Total (PPO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area includes these counties in South Carolina:

BlueCross Total (PPO) – Upstate (001): Greenville, Lancaster, Oconee, Pickens, Spartanburg, and York.

BlueCross Total (PPO) – Midlands/Coastal (002): Aiken, Dillon, Fairfield, Horry, Kershaw, Lexington, Marion, Marlboro, Newberry, Richland, Saluda, and Sumter.

BlueCross Total (PPO) – Lowcountry (003): Berkeley, Colleton, Dorchester, Georgetown, and Jasper.

BlueCross Total (PPO) has a network of doctors, hospitals, pharmacies, and other providers, as well as access to out-of-network providers. As a member of our plan, you do not need a referral from a Primary Care Provider to see a Specialist or to obtain a service. However, you are required to obtain prior authorization from our plan for some services.

For coverage and costs of Original Medicare, look in your current "**Medicare & You**" handbook. View it online at Medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 7 days a week, 24 hours a day. TTY users should call 1-877-486-2048.

Customer Service has free language interpreter services available for non-English speakers. This information is available in other formats. To get this information in other formats, please call Customer Service.

For more information or to enroll, call us at 1-800-930-2836 (TTY users should call 711), or visit us at SCBluesMedAdvantage.com. We are available for phone calls from October 1 to March 31; you can call us 8 am to 8 pm, 7 days a week. For all other times, we're here 8 am to 8 pm, Monday through Friday. Calls to this number are answered by a licensed insurance agent.

H8003_SB2027_M

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
Premiums and Benefits	**BlueCross Total (PPO)**
Monthly Plan Premium	BlueCross Total – Upstate (001): $39 per month. BlueCross Total – Midlands/Coastal (002): $39 per month. BlueCross Total – Lowcountry (003): $48 per month. In addition, you must keep paying your Medicare Part B premiums.
Deductible	No Deductible.
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: • $9,250 for services you receive from in-network providers. • $13,500 for services you receive from in and out-of-network providers combined. If you reach the limit on out-of-pocket costs, you keep getting hospital and medical services covered and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.

COVERED MEDICAL AND HOSPITAL BENEFITS	
Benefits/Services	**BlueCross Total (PPO)**
Inpatient Hospital	**In-Network:** Days 1-4: You pay a $425 copayment per day. Days 5-90: You pay a $0 copayment per day. **Out-of-Network:** You pay 40% coinsurance of the total cost. This benefit will begin on day 1 each time you are admitted to a specific facility type. You pay your cost share per admission. **May require prior authorization.**

Benefits/Services	BlueCross Total (PPO)
Outpatient Hospital	**In-Network:** You pay a $0 - $450 copayment. You pay a $0 copayment for a colonoscopy even if a polyp is found and removed during the procedure. You pay a $400 copayment for each Medicare covered observation service. **Out-of-Network:** You pay 40% coinsurance of the total cost. **May require prior authorization.**
Ambulatory Surgical Center	**In-Network:** You pay a $0 - $125 copayment. You pay a $0 copayment for a colonoscopy even if a polyp is found and removed during the procedure. **Out-of-Network:** You pay 40% coinsurance of the total cost. **May require prior authorization.**
Doctor's Office Visits	**In-Network:** Primary care physician: You pay a $0 copayment. Specialist: You pay a $40 copayment. **Out-of-Network:** Primary care physician: You pay a $30 copayment. Specialist: You pay a $55 copayment.
Telehealth	Primary care physician: You pay a $0 copayment. Dermatology Specialist: You pay a $25 copayment. Psychiatric and Mental Health services: You pay a $40 copayment. *Members must use Blue CareOnDemand® Powered by MD Live® Virtual Care for the Telehealth services. First time users will need to register by logging in to My Health Toolkit®.
Preventive Care ***(e.g., flu vaccine, diabetic screenings)***	**In-Network:** You pay a $0 copayment. **Out-of-Network:** You pay 40% coinsurance of the total cost.

Benefits/Services	BlueCross Total (PPO)
Preventive Care *(e.g., flu vaccine, diabetic screenings)* (continued)	Preventive care includes: Abdominal aortic aneurysm screening; Annual wellness visit; Bone mass measurement; Breast cancer screening (mammograms); Cardiovascular disease risk reduction visit; Cardiovascular disease screening; Cervical and vaginal cancer screening; Colorectal cancer screening; Depression screening; Diabetes screening and training; Diabetes self-management training; Health and wellness education programs; HIV screening; Medical nutrition therapy; Medicare Diabetes Prevention Program; Obesity screening and therapy; Pre-exposure prophylaxis for HIV prevention; Prostate cancer screening; Screening and counseling to reduce alcohol misuse; Screening for lung cancer; Screening for Hepatitis C virus infection; Screening for sexually transmitted infections (STIs) and counseling to prevent STIs; Smoking and tobacco use cessation; Vision care; Welcome to Medicare initial visit; Vaccines, including flu shots and pneumococcal shots; Annual Physical.
Emergency Care	You pay a $115 copayment, waived if admitted within 24 hours. Worldwide Emergency Coverage: You pay 20% coinsurance of the total cost. Maximum Coverage is $25,000.
Urgently Needed Services	You pay a $10 copayment, waived if admitted within 24 hours. Worldwide Urgent Coverage: You pay a $45 copayment.
Diagnostic Services / Labs/ Imaging	**In-Network:** Diagnostic tests and procedures: You pay a $0 - $125 copayment. You pay a $0 copayment for diagnostic EKG and diagnostic colorectal screening. Lab services: You pay a $5 copayment for professional lab services at a Primary Care Physician/Specialist office. You pay a $15 copayment for outpatient lab services. Diagnostic Radiology Services (such as MRI, CAT Scan): You pay a $0 - $325 copayment. You pay a $0 copayment for diagnostic mammograms and ultrasounds. X-rays: You pay a $0 copayment. Therapeutic radiology services (such as radiation treatment for cancer): You pay 20% coinsurance of the total cost. **Out-of-Network:** Diagnostic tests and procedures: You pay 40% coinsurance of the total cost. Lab services: You pay 40% coinsurance of the total cost. Diagnostic Radiology Services (such as MRI, CAT Scan): You pay 40% coinsurance of the total cost. X-rays: You pay 40% coinsurance of the total cost. Therapeutic radiology services (such as radiation treatment for cancer): You pay 40% coinsurance of the total cost. **May require prior authorization.**

Benefits/Services	BlueCross Total (PPO)
Hearing Services	**<u>In-Network:</u>** Medicare-covered hearing exam: You pay a $45 copayment. Routine hearing exam (up to 1 visit every year): You pay a $45 copayment using Preferred hearing provider. **Hearing Aid (up to 2 hearing aids every year)**: You pay a $699 - $999 copayment using Preferred hearing provider for up to 2 hearing aids per year (one per ear, each year). The copayment range is based on different types and styles of hearing aids. The lower range $699 is for the Advanced hearing aid type and the higher range $999 is for the Premium hearing aid type. **<u>Out-of-Network:</u>** Medicare-covered hearing exam: You pay a $45 copayment. Routine hearing exam (up to 1 visit every year): You pay 40% coinsurance of the total cost. **Hearing Aid (Not using Preferred hearing provider)**: You pay 90% coinsurance of the total cost.
Preventive Dental (non-Medicare covered)	**<u>In-Network:</u>** *You pay a $0 copayment. You get 2 preventive dental visits to include an oral exam and cleaning; 1 dental bitewing x-ray, and two fillings per year (fluoride treatment not covered). **<u>Out-of-Network</u>**: *You pay 50% coinsurance of the total cost. You get 2 preventive dental visits to include an oral exam and cleaning; 1 dental bitewing x-ray, and two fillings per year (fluoride treatment not covered). **In-network services receive the BCBS discount (Going to an out-of-network dentist may cost you more than using a contracted in-network dentist. We pay up to 50% coinsurance of the total cost for reasonable and customary charges for out-of-network claims.)**
Comprehensive Dental (Non-Medicare Covered)	**<u>In-Network:</u>** *You pay 50% coinsurance of the total cost. **<u>Out-of-Network</u>**: *You pay 50% coinsurance of the total cost.

Benefits/Services	BlueCross Total (PPO)
Comprehensive Dental (Non-Medicare Covered) (continued)	Non-routine services, diagnostic services, restorative services, endodontics, extractions, prosthodontics, other oral/maxillofacial surgery, periodontics, and other services (i.e., dentures, root canals). We **Do Not** cover dental implants including the procedures related to the implant, implant crowns, implant abutments, or any other service related to the implant). **In-network services receive the BCBS discount (Going to an out-of-network dentist may cost you more than using a contracted in-network dentist. We pay up to 50% coinsurance of the total cost for reasonable and customary charges for out-of-network claims.)** *Maximum Annual Comprehensive Dental Allowance: $2,500. See your EOC for details.
Comprehensive Dental (Medicare Covered)	**In-Network:** You pay a $50 copayment. **Out-of-Network**: You pay a $50 copayment. See your EOC for details.
Vision Services	**In-Network:** **Medicare covered:** You pay a $0 - $50 copayment. You pay a $0 copayment for certain preventive and diagnostic eye exams such as yearly Diabetic Retinopathy and Glaucoma tests. You pay a $50 copayment for all other Medicare-covered vision services. **Non-Medicare Covered:** You pay a $0 copayment for non-Medicare-covered routine eye exams. You pay a $25 - $135 copayment for non-Medicare-covered eyeglass lenses. You receive a $100 - $150 allowance for non-Medicare-covered frames or contact lenses. **Out-of-Network:** **Medicare covered:** You pay a $50 copayment for Medicare covered vision services. **Non-Medicare Covered:** You pay 90% coinsurance of the total cost for non-Medicare covered eyewear and routine eye exams. See your EOC for details.

Benefits/Services	BlueCross Total (PPO)
Mental Health Care Inpatient hospital - psychiatric	**In-Network:** Days 1-3: You pay a $695 copayment per day. Days 4-90: You pay a $0 copayment per day. **Out-of-Network:** You pay 40% coinsurance of the total cost. **May require prior authorization.**
Mental Health Care Outpatient group therapy/ individual therapy	**In-Network:** Mental Health (Group/Individual): You pay a $50 copayment. Psychiatric Service (Group/Individual): You pay a $45 copayment. **Out-of-Network:** Mental Health or Psychiatric Services: You pay 40% coinsurance of the total cost.
Skilled Nursing Facility (SNF)	**In-Network:** Days 1-20: You pay a $0 copayment per day. Days 21-100: You pay a $221 copayment per day. **Out-of-Network:** You pay 40% coinsurance of the total cost. Our plan covers up to 100 days in a SNF. **May require prior authorization.**
Outpatient Rehabilitation	**In-Network Total Upstate:** Occupational therapy: You pay a $35 copayment. Physical therapy and Speech-Language therapy: You pay a $25 copayment. **In-Network Total Midlands/Coastal and Lowcountry:** Occupational therapy: You pay a $35 copayment. Physical therapy and Speech-Language therapy: You pay a $20 copayment. **Out-of-Network:** Occupational therapy: You pay a $55 copayment. Physical therapy and Speech-Language therapy: You pay a $55 copayment. **May require prior authorization.**

Benefits/Services	BlueCross Total (PPO)
Ambulance	**<u>In-Network Total Upstate:</u>** Ground Ambulance: You pay a $375 copayment. Air Ambulance: You pay a $390 copayment. **<u>In-Network Total Midlands/Coastal and Lowcountry:</u>** Ground Ambulance: You pay a $390 copayment. Air Ambulance: You pay a $405 copayment. **<u>Out-of-Network Total Upstate:</u>** Ground Ambulance: You pay a $375 copayment. Air Ambulance: You pay a $390 copayment. **<u>Out-of-Network Total Midlands/Coastal and Lowcountry:</u>** Ground Ambulance: You pay a $390 copayment. Air Ambulance: You pay a $405 copayment. **May require prior authorization for non-emergency transportation.**
Transportation	**<u>In-Network:</u>** You pay a $0 copayment for 20 one-way trips per year to any health-related location. **<u>Out-of-Network:</u>** You pay 90% coinsurance of the total cost. **Note:** Transportation is provided during normal working hours. Mileage limits are based on your geographic location. See your EOC for details.
Medicare Part B Drugs	**<u>In-Network:</u>** Medicare Part B Insulin drugs: You pay a $35 copayment. Other Part B drugs to include chemotherapy drugs: You pay 0% - 20% coinsurance of the total cost. **<u>Out-of-Network:</u>** Medicare Part B Insulin drugs: You pay a $35 copayment. Other Part B drugs to include chemotherapy drugs: You pay 40% coinsurance of the total cost. **May require prior authorization.**

Additional Benefits/Services	BlueCross Total (PPO)
Chiropractic Office Visits – Medicare Covered*	**In-Network:** You pay a $15 copayment. **Out-of-Network:** You pay 40% coinsurance of the total cost. *Only manual manipulation of the spine to correct subluxation is covered.
Fitness Benefit	**In-Network:** You pay a $0 copayment for a Health participating fitness center, home fitness kit (1 per year), and access to digital workouts. Home fitness kit options (1 per year) – Strength Kit (includes resistance tubing), Toning Kit (includes Pilates ball), Yoga Kit (includes yoga mat), Self-Care Kit (includes foam roller), and Walking Kit (includes pedometer). **Out-of-Network:** You pay 90% coinsurance of the total cost. See your EOC for details.
Foot Care Podiatry services	**In-Network:** You pay a $40 copayment. **Out-of-Network:** You pay 40% coinsurance of the total cost.
Medical Equipment/Supplies	**In-Network:** Home Infusion: You pay 15% coinsurance of the total cost. Durable medical, prosthetics, and other Part B services: You pay 20% coinsurance of the total cost. **Out-of-Network:** You pay 40% coinsurance of the total cost. **May require prior authorization.**
Diabetic Monitors	**In-Network:** You pay 0% coinsurance for Preferred brand glucose monitors. You pay 20% coinsurance for other brands with approved medical exception.

Additional Benefits/Services	BlueCross Total (PPO)
Diabetic Monitors (continued)	**Out-of-Network:** You pay 40% coinsurance of the total cost.
Diabetic supplies and Services	**In-Network:** You pay 0% coinsurance for Preferred brand supplies, including test strips, solutions, lancets, and lancing devices. You pay 20% coinsurance for other brands with approved medical exception. **Out-of-Network:** You pay 40% coinsurance of the total cost.
Home Health Care	**In-Network:** You pay 0% coinsurance of the total cost. **Out-of-Network:** You pay 40% coinsurance of the total cost. **Prior authorization is required**
Meal Program	**In-Network:** You pay a $0 copayment for meals upon discharge from a hospital or rehab facility. Two meals per day for 5 days. **Out-of-Network:** You pay 90% coinsurance of the total cost.

Over-the-Counter (OTC)

In-Network:

BlueCross Total – Upstate (001): You receive $40 per quarter for a total of $160 per year in Over-the-Counter items with free shipping. Orders placed once per quarter via phone, catalog, or vendor website.

BlueCross Total – Midlands/Coastal (002): You receive $40 per quarter for a total of $160 per year in Over-the-Counter items with free shipping. Orders placed once per quarter via phone, catalog, or vendor website.

BlueCross Total – Lowcountry (003): You receive $40 per quarter for a total of $160 per year in Over-the-Counter items with free shipping. Orders placed once per quarter via phone, catalog, or vendor website.

Out-of-Network:

You receive $40 per quarter for a total of $160 per year in Over-the-Counter items.

Reimbursement for eligible items will be reimbursed after submitting valid receipts and reimbursement request form.

See EOC for details.

Visitor Travel

The Visitor/Travel Program will include BlueCross Total network coverage of all Part A, Part B, and Supplemental benefits offered by your plan outside your service area in 47 states and 1 territory and 1 district: Alabama, Arizona, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming. For some of the states listed, MA PPO networks are only available in portions of the state. These areas are subject to change, see EOC for details.

Prescription Drug Coverage

Yearly Deductible: During this stage, you pay the full cost of your Tier 3, 4 and 5 drugs until you have reached the yearly deductible. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines.

Initial Coverage Stage: During this stage, the plan pays its share of the cost of your drugs, and you pay your share. You stay in the Initial Coverage Stage until your total out-of-pocket costs reach $2,400. You then move on to the Catastrophic Coverage Stage.

Catastrophic Coverage: The Catastrophic coverage Stage is the third and final stage. **If you reach the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs.**

<table>
<tr><th colspan="2">PRESCRIPTION DRUG BENEFITS</th></tr>
<tr><td>Deductible</td><td>Prescription Drug Deductible: $600 for Tiers 3, 4 and 5.</td></tr>
<tr><td>Initial Coverage</td><td>You pay the following until your total yearly drug costs reach $2,400. Total yearly drug costs are the drug costs paid by both you and your Part D plan.
<table>
<tr><th colspan="4">Standard Retail Cost-Sharing</th></tr>
<tr><th>Tier</th><th>One-month supply</th><th>Two-month supply</th><th>Three-month supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$5 copayment</td><td>$10 copayment</td><td>$15 copayment</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$10 copayment</td><td>$20 copayment</td><td>$30 copayment</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>25% coinsurance</td><td>25% coinsurance</td><td>25% coinsurance</td></tr>
<tr><td>Tier 4 (Non-Preferred Drug)</td><td>31% coinsurance</td><td>31% coinsurance</td><td>31% coinsurance</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>26% coinsurance</td><td>Not Applicable</td><td>Not Applicable</td></tr>
<tr><td>Tier 6 (Select Care Drugs)</td><td>$0 copayment</td><td>$0 copayment</td><td>$0 copayment</td></tr>
</table></td></tr>
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Preferred Retail Cost-Sharing			
Tier	**One-month supply**	**Two-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	$0 copayment	$0 copayment	$0 copayment
Tier 2 (Generic)	$5 copayment	$10 copayment	$15 copayment
Tier 3 (Preferred Brand)	23% coinsurance	23% coinsurance	23% coinsurance
Tier 4 (Non-Preferred Drug)	26% coinsurance	26% coinsurance	26% coinsurance
Tier 5 (Specialty Tier)	26% coinsurance	Not Applicable	Not Applicable
Tier 6 (Select Care Drugs)	$0 copayment	$0 copayment	$0 copayment
Standard Mail Order			
Tier	**One-month supply**	**Two-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	$0 copayment	$0 copayment	$0 copayment
Tier 2 (Generic)	$5 copayment	$10 copayment	$15 copayment
Tier 3 (Preferred Brand)	23% coinsurance	23% coinsurance	23% coinsurance
Tier 4 (Non-Preferred Drug)	26% coinsurance	26% coinsurance	26% coinsurance
Tier 5 (Specialty Tier)	26% coinsurance	Not Applicable	Not Applicable
Tier 6 (Select Care Drugs)	$0 copayment	$0 copayment	$0 copayment

Your cost-sharing may be different if you use a Long-Term Care pharmacy, or an out-of-network pharmacy, or if you purchase a long-term supply (up to 90 days) of a drug.

PRESCRIPTION DRUG BENEFITS	
	Please call us or see the plan's **"Evidence of Coverage"** on our website (SCBluesMedAdvantage.com) for complete information about your costs for covered drugs.

Limitations, copayments, and restrictions may apply. Benefits, premiums, copayments, or coinsurance may change on January 1 of each year.

Out-of-network/non-contracted providers are under no obligation to treat BlueCross Total members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our Customer Service number, 1-855-204-2744 (TTY users should call 711), or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-855-204-2744 (TTY: 711) or speak to your provider.

Español: 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 1-844-396-0183 (TTY: 711) o hable con su proveedor. (Spanish)

中文: 注意：如果您說[中文]，我們可以為您提供免費語言援助服務，也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-844-396-0188（TTY：711）或與您的提供者討論。(Chinese)

Tiếng Việt: LƯU Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ và dịch vụ bổ sung phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi 1-844-389-4838 (TTY: 711) hoặc trao đổi với nhà cung cấp dịch vụ của quý vị. (Vietnamese)

РУССКИЙ: ВНИМАНИЕ! Если вы говорите на русском языке, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-844-389-4840 (TTY: 711) или обратитесь к своему поставщику услуг. (Russian)

Tagalog: PAALALA: Kung nagsasalita ka ng Tagalog, available ang mga libreng serbisyo ng tulong sa wika para sa iyo. Available rin nang walang bayad ang mga naaangkop na auxiliary na tulong at serbisyo para magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-844-389-4839 (TTY: 711) o makipag-usap sa iyong provider. (Tagalog)

Português do Brasil: ATENÇÃO: Se você fala português, há serviços gratuitos de assistência linguística disponíveis para você. Assistência e serviços auxiliares próprios para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-844-396-0182 (TTY: 711) ou fale com seu provedor. (Portuguese)

Français : NOTE : Si vous parlez français, des services gratuits d'assistance linguistique sont à votre disposition. Des aides et des services auxiliaires appropriés pouvant fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-844-396-0190 (TTY : 711) ou adressez-vous à votre prestataire. (French)

ગુજરાતી: ધ્યાન આપો૭જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે- યોગ્ય ઓિકઝલરી સહાય અને એક્સેિસબલ ફોમટમાં માિહતી પૂરી પાડવા માટેની સેવાઓ પણ િવના મૂલ્યે ઉપલબ્ધ છે- 1-844-641-2898 (TTY: 711) પર કોલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો- (Gujarati)

Deutsch: 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 unter 1-844-396-0191 (TTY: 711) an oder sprechen Sie mit Ihrem Anbieter. (German)

한국어: 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-844-396-0187(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오. (Korean)

العربية: 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 1-844-396-0189 (خدمة الهاتف النصّي: 711) أو تحدث إلى مقدم الخدمة". (Arabic)

Українська мова: УВАГА! Якщо ви розмовляєте українською мовою, вам доступні безкоштовні мовні послуги. Відповідні

допоміжні засоби й послуги для надання інформації в доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1- 844-641-2897 (TTY: 711) або зверніться до свого постачальника. (Ukrainian)

日本語: 注 : 日本語を希望する場合、無料の言語支援サービスをご利用いただけます。アクセシブル (誰でも利用できるよう配慮された) な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-844-396-0191 (TTY: 711) までお電話ください。または、ご利用の事業者にお問い合わせください。(Japanese)

ไทย: โปรดทราบ: หากคุณพูดภาษา ไทย เรามีบริการความช่วยเหลือด้านแปลภาษาฟรี นอกจากนี้ ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อที่ 1-844-641-2896 (TTY: 711) หรือปรึกษาผู้ให้บริการของคุณ (Thai)

ລາວ: ຊຸນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫທ້ ່ານ. ມີເຄື ່ອງຊ ່ວຍ ແລະ ການບໍ ່ລິການແບບບ ່ ່ເສຍຄ ່ າທ ີ ່ ເໝ ່ ະສົມເພ ື ່ ອໃຫ ້ ຂ ໍ ້ ມ ູ ນໃນຮ ູ ບແບບທ ີ ່ ສ າ ມ າ ດ ເ ຂ ົ ້ າ ເ ຖ ິ ງ ໄ ດ ້ . ໂ ທ ຫ າ ເ ບ ີ 1-844-641-2895 (TTY: 711) ຫ ື ຶ ລ ົ ມ ກ ັ บ ຜ ູ ້ ໃ ຫ ບ ໍ ລ ິ ก า ร ข อ ง ท ่ า น . (Lao)

ि हंदी : ◌ान दें9 यिद आप ि हंदी बोलते हैं, तो आपके ि लए ि नः शु◌ भाषा सहायता सेवाएं उपल◌ होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के ि लए उपयु◌ सहायक साधन और सेवाएँ भी ि नः शु◌ उपल◌ हैं। 1-844-641-2894 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें। (Hindi)