BlueCross BlueShield of Oklahoma

2027

Individual Plan Comparison Chart

Participating Provider Coverage Shown[1]

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

Bronze	Blue Advantage Bronze PPO℠		Blue Preferred Bronze PPO℠
	Support HSA	Standard HSA	Signature[2]
Deductible[3]	Individual $8,000 / Family $16,000	Individual $7,500 / Family $15,000	Individual $6,000 / Family $12,000
Coinsurance	50%	50%	50%
Out-of-Pocket Maximum (includes deductible)[3]	Individual $12,000 / Family $24,000	Individual $12,000 / Family $24,000	Individual $10,150 / Family $20,300
Primary Care Office Visit	0%	$50 copay	40%
Virtual Visits	50%	$50 copay	40%
Specialist Office Visit	50%	$100 copay	50%
Mental and Behavioral Health/ Substance Use Disorder Office Visit	50%	$50 copay	50%
Emergency Room	$2,500 copay	50%	$950 per occurrence deductible, then 50%
Urgent Care	$100	$75 copay	50%
Inpatient Hospital Services	50%	50%	$400 per occurrence deductible, then 50%
Outpatient Surgery[4]	50%	50%	$300 per occurrence deductible, then 50%
Outpatient X-Rays and Diagnostic Imaging[4]	50%	50%	50%
Outpatient Imaging (CT/PET Scans/MRIs)[4]	50%	50%	50%
Network	Blue Advantage PPO℠	Blue Advantage PPO℠	Blue Preferred PPO℠
HSA Eligible[5]	Yes	Yes	No
Outpatient Prescription Drugs - Preferred Pharmacy[6]	$0 / $10 / 35% / 45% / 50% / 55%[7]	$25 / $50 / $100 / $500[8]	20% / 25% / 30% / 35% / 45% / 50%[7]
Outpatient Prescription Drugs - Non-Preferred Pharmacy[6]	$10 / $20 / 40% / 45% / 50% / 55%[7]	$25 / $50 / $100 / $500[8]	25% / 30% / 35% / 40% / 45% / 50%[7]
Prescription Drug Benefit Utilization Management Programs[9]	**Specialty Pharmacy Program:** To be eligible for maximum benefits, specialty medications must be obtained through an in-network Specialty Pharmacy provider. **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 receive authorization from BCBSOK. 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 are reduced when non-participating providers are used. This is a summary of benefit highlights only. All benefits shown represent what the member would pay.

2 This plan is not available on the Health Insurance Marketplace® in Oklahoma.

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 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.

5 As a reminder, a Health Savings Account (HSA) has tax and legal ramifications. Blue Cross and Blue Shield of Oklahoma 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.

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 prescription drugs with a lower possible member cost-share amount. Preferred pharmacy pricing is not available for 100% cost sharing plans.

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

8 Four prescription drug payment level tiers: Generic / Preferred Brand / Non-Preferred Brand / Specialty. Costs are for outpatient prescriptions through a preferred pharmacy. Deductible may apply to certain tiers. See your Summary of Benefits and Coverage for details.

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.

Blue Cross and Blue Shield of Oklahoma, 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 Oklahoma

2027

Individual Plan Comparison Chart

Participating Provider Coverage Shown[1]

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

Bronze	MyBlue Bronze HMO℠ [2]			
	Signature [3]	Balance HSA	Champion HSA	Standard HSA
Deductible [4]	Individual $7,400 / Family $14,800	Individual $11,750 / Family $23,500	Individual $5,000 / Family $10,000	Individual $7,500 / Family $15,000
Coinsurance	50%	0%	50%	50%
Out-of-Pocket Maximum (includes deductible) [4]	Individual $10,150 / Family $20,300	Individual $11,750 / Family $23,500	Individual $11,100 / Family $22,200	Individual $12,000 / Family $24,000
Primary Care Office Visit	$95 copay	0%	$45 copay	$50 copay
Virtual Visits	$95 copay	0%	$45 copay	$50 copay
Specialist Office Visit	50%	0%	50%	$100 copay
Mental and Behavioral Health/ Substance Use Disorder Office Visit	40%	0%	50%	$50 copay
Emergency Room	$950 per occurrence deductible, then 50%	0%	$2,500 copay	50%
Urgent Care	$145 copay	0%	$65 copay	$75 copay
Inpatient Hospital Services	$400 per occurrence deductible, then 50%	0%	50%	50%
Outpatient Surgery [5]	$600 per occurrence deductible, then 50%	0%	50%	50%
Outpatient X-Rays and Diagnostic Imaging [5]	50%	0%	50%	50%
Outpatient Imaging (CT/PET Scans/MRIs) [5]	50%	0%	50%	50%
Network	MyBlue HMO℠	MyBlue HMO℠	MyBlue HMO℠	MyBlue HMO℠
HSA Eligible	No	Yes	Yes	Yes
Outpatient Prescription Drugs - Preferred Pharmacy [6]	$10 / $20 / 30% / 35% / 45%/ 50% [7]	0%	$5 / $15 / 35% / 45% / 50% / 55% [7]	$25 / $50 / $100 / $500 [8]
Outpatient Prescription Drugs - Non-Preferred Pharmacy [6]	$15 / $30 / 35% / 40% / 45% / 50% [7]	0%	$15 / $25 / 40% / 45% / 50% / 55% [7]	$25 / $50 / $100 / $500 [8]
Prescription Drug Benefit Utilization Management Programs [9]	**Specialty Pharmacy Program:** To be eligible for maximum benefits, specialty medications must be obtained through an in-network Specialty Pharmacy provider. **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 receive authorization from BCBSOK. 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 are reduced when non-participating providers are used. This is a summary of benefit highlights only. All benefits shown indicate member responsibility.

2 **MyBlue HMO℠ plans are not available in Rating Areas 1 and 2 (Comanche, Le Flore, and Sequoyah counties).**

3 This plan is not available on the Health Insurance Marketplace® in Oklahoma.

4 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.

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.

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

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Individual Plan Comparison Chart

Participating Provider Coverage Shown[1]

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Silver	Blue Preferred Silver PPO℠
	Signature[2]
Deductible[3]	Individual $1,000 / Family $2,000
Coinsurance	50%
Out-of-Pocket Maximum (includes deductible)[3]	Individual $12,000 / Family $24,000
Primary Care Office Visit	40%
Virtual Visits	40%
Specialist Office Visit	50%
Mental and Behavioral Health/ Substance Use Disorder Office Visit	40%
Emergency Room	$950 per occurrence deductible, then 50%
Urgent Care	50%
Inpatient Hospital Services	$400 per occurrence deductible, then 50%
Outpatient Surgery[4]	$300 per occurrence deductible, then 50%
Outpatient X-Rays and Diagnostic Imaging[4]	50%
Outpatient Imaging (CT/PET Scans/MRIs)[4]	50%
Network	Blue Preferred PPO℠
HSA Eligible	No
Outpatient Prescription Drugs - Preferred Pharmacy[5]	20% / 25% / 30% / 35% / 45% / 50%[6]
Outpatient Prescription Drugs - Non-Preferred Pharmacy[5]	25% / 30% / 35% / 40% / 45% / 50%[6]
Prescription Drug Benefit Utilization Management Programs[7]	**Specialty Pharmacy Program:** To be eligible for maximum benefits, specialty medications must be obtained through an in-network Specialty Pharmacy provider. **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 receive authorization from BCBSOK. You may also need to meet certain criteria or try more cost-effective drugs first. **90-Day Supply:** You may receive up to a 90-day supply for covered prescription drugs through the home delivery program or at select retail pharmacies depending on your prescription drug benefit.

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5 Prescription drug benefit coverage starts after annual medical deductible has been met, not counting copays. Retail stores in the Preferred Pharmacy Network offer members prescription drugs with a lower possible member cost-share amount.
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Individual Plan Comparison Chart

Participating Provider Coverage Shown[1]

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

Silver	Blue Advantage Silver PPO℠			
	Champion	Signature[2]	Balance	Standard
Deductible[3]	Individual $3,100 / Family $6,200	Individual $1,400 / $2,800	Individual $7,000 / Family $14,000	Individual $6,400 / Family $12,800
Coinsurance	40%	50%	40%	40%
Out-of-Pocket Maximum (includes deductible)[3]	Individual $10,200 / Family $20,400	Individual $11,000 / Family $22,000	Individual $10,700 / Family $21,400	Individual $10,300 / Family $20,600
Primary Care Office Visit	$40 copay	$30 copay	$35 copay	$40 copay
Virtual Visits	$40 copay	$30 copay	$35 copay	$40 copay
Specialist Office Visit	$90 copay	50%	$75 copay	$80 copay
Mental and Behavioral Health/ Substance Use Disorder Office Visit	$40 copay	0%	$35 copay	$40 copay
Emergency Room	$2,500 copay	$950 per occurrence deductible, then 50%	$2,500 copay	40%
Urgent Care	$60 copay	50%	$55 copay	$60 copay
Inpatient Hospital Services	40%	$400 per occurrence deductible, then 50%	40%	40%
Outpatient Surgery[4]	40%	$300 per occurrence deductible, then 50%	40%	40%
Outpatient X-Rays and Diagnostic Imaging[4]	40%	50%	40%	40%
Outpatient Imaging (CT/PET Scans/MRIs)[4]	40%	50%	40%	40%
Network	Blue Advantage PPO℠	Blue Advantage PPO℠	Blue Advantage PPO℠	Blue Advantage PPO℠
HSA Eligible	No	No	No	No
Outpatient Prescription Drugs - Preferred Pharmacy[5]	$5 / $15 / $90 / 45% / 50% / 55%[6]	20% / 25% / 30% / 35% / 45% / 50%[6]	$5 / $15 / $100 / 45% / 50% / 55%[6]	$20 / $40 / $80 / $350[7]
Outpatient Prescription Drugs - Non-Preferred Pharmacy[5]	$15 / $25 / $115 / 45% / 50% / 55%[6]	25% / 30% / 35% / 40% / 45% / 50%[6]	$15 / $25 / $125 / 45% / 50% / 55%[6]	$20 / $40 / $80 / $350[7]
Prescription Drug Benefit Utilization Management Programs[8]	**Specialty Pharmacy Program:** To be eligible for maximum benefits, specialty medications must be obtained through an in-network Specialty Pharmacy provider. **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 receive authorization from BCBSOK. You may also need to meet certain criteria or try more cost-effective drugs first. **90-Day Supply:** You may receive up to a 90-day supply for covered prescription drugs through the home delivery program or at select retail pharmacies depending on your prescription drug benefit.			

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Silver	MyBlue Silver HMO℠ [2]			
	Champion	Balance	Signature [3]	Standard
Deductible [4]	Individual $3,100 / Family $6,200	Individual $7,000 / Family $14,000	Individual $5,500 / Family $11,000	Individual $6,400 / Family $12,800
Coinsurance	40%	40%	40%	40%
Out-of-Pocket Maximum (includes deductible) [4]	Individual $10,200 / Family $20,400	Individual $10,700 / Family $21,400	Individual $7,500 / Family $15,000	Individual $10,300 / Family $20,600
Primary Care Office Visit	$40 copay	$35 copay	$0 copay	$40 copay
Virtual Visits	$40 copay	$35 copay	$0 copay	$40 copay
Specialist Office Visit	$90 copay	$75 copay	40%	$80 copay
Mental and Behavioral Health/ Substance Use Disorder Office Visit	$40 copay	$35 copay	40%	$40 copay
Emergency Room	$2,500 copay	$2,500 copay	$950 per occurrence deductible, then 40%	40%
Urgent Care	$60 copay	$55 copay	$20 copay	$60 copay
Inpatient Hospital Services	40%	40%	$250 per occurrence deductible, then 40%	40%
Outpatient Surgery [5]	40%	40%	$200 per occurrence deductible, then 40%	40%
Outpatient X-Rays and Diagnostic Imaging [5]	40%	40%	40%	40%
Outpatient Imaging (CT/PET Scans/MRIs) [5]	40%	40%	40%	40%
Network	MyBlue HMO℠	MyBlue HMO℠	MyBlue HMO℠	MyBlue HMO℠
HSA Eligible	No	No	No	No
Outpatient Prescription Drugs - Preferred Pharmacy [6]	$5 / $15 / $90 / 45% / 50% / 55% [7]	$5 / $15 / $100 / 45% / 50% / 55% [7]	$0 / $15 / 30% / 35% / 45% / 50% [7]	$20 / $40 / $80 / $350 [8]
Outpatient Prescription Drugs - Non-Preferred Pharmacy [6]	$15 / $25 / $115 / 45% / 50% / 55% [7]	$15 / $25 / $125 / 45% / 50% / 55% [7]	$10 / $25 / 35% / 40% / 45% / 50% [7]	$20 / $40 / $80 / $350 [8]
Prescription Drug Benefit Utilization Management Programs [9]	**Specialty Pharmacy Program:** To be eligible for maximum benefits, specialty medications must be obtained through an in-network Specialty Pharmacy provider. **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 receive authorization from BCBSOK. You may also need to meet certain criteria or try more cost-effective drugs first. **90-Day Supply:** You may receive up to a 90-day supply for covered prescription drugs through the home delivery program or at select retail pharmacies depending on your prescription drug benefit.			

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Gold	Blue Advantage Gold PPO℠		
	Secure	Balance	Standard
Deductible[2]	Individual $1,800 / Family $3,600	Individual $2,500 / Family $5,000	Individual $2,500 / Family $5,000
Coinsurance	30%	20%	25%
Out-of-Pocket Maximum (includes deductible)[2]	Individual $7,800 / Family $15,600	Individual $8,600 / Family $17,200	Individual $8,600 / Family $17,200
Primary Care Office Visit	$15 copay	$0 copay	$30 copay
Virtual Visits	$15 copay	$0 copay	$30 copay
Specialist Office Visit	$50 copay	$50 copay	$60 copay
Mental and Behavioral Health/ Substance Use Disorder Office Visit	$15 copay	$0 copay	$30 copay
Emergency Room	$1,000 copay	$1,000 copay	25%
Urgent Care	$35 copay	$30 copay	$45 copay
Inpatient Hospital Services	30%	20%	25%
Outpatient Surgery[3]	40%	30%	25%
Outpatient X-Rays and Diagnostic Imaging[3]	40%	30%	25%
Outpatient Imaging (CT/PET Scans/MRIs)[3]	40%	30%	25%
Network	Blue Advantage PPO℠	Blue Advantage PPO℠	Blue Advantage PPO℠
HSA Eligible	No	No	No
Outpatient Prescription Drugs - Preferred Pharmacy[4]	$15 / $25 / 30% / 45% / 50% / 55%[5]	$15 / $25 / $50 / 45% / 50% / 55%[5]	$15 / $30 / $60 / $250[6]
Outpatient Prescription Drugs - Non-Preferred Pharmacy[4]	$25 / $35 / 35% / 45% / 50% / 55%[5]	$25 / $35 / $75 / 45% / 50% / 55%[5]	$15 / $30 / $60 / $250[6]
Prescription Drug Benefit Utilization Management Programs[7]	**Specialty Pharmacy Program:** To be eligible for maximum benefits, specialty medications must be obtained through an in-network Specialty Pharmacy provider. **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 receive authorization from BCBSOK. 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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	Secure	Standard	Signature [3]
Deductible [4]	Individual $1,800 / Family $3,600	Individual $2,500 / Family $5,000	Individual $700 / Family $1,400
Coinsurance	30%	25%	40%
Out-of-Pocket Maximum (includes deductible) [4]	Individual $7,800 / Family $15,600	Individual $8,600 / Family $17,200	Individual $7,500 / Family $15,000
Primary Care Office Visit	$15 copay	$30 copay	$40 copay
Virtual Visits	$15 copay	$30 copay	$40 copay
Specialist Office Visit	$50 copay	$60 copay	40%
Mental and Behavioral Health/ Substance Use Disorder Office Visit	$15 copay	$30 copay	40%
Emergency Room	$1,000 copay	25%	$950 per occurrence deductible, then 35%
Urgent Care	$35 copay	$45 copay	$90 copay
Inpatient Hospital Services	30%	25%	$400 per occurrence deductible, then 40%
Outpatient Surgery [5]	40%	25%	$300 per occurrence deductible, then 40%
Outpatient X-Rays and Diagnostic Imaging [5]	40%	25%	40%
Outpatient Imaging (CT/PET Scans/MRIs) [5]	40%	25%	40%
Network	MyBlue HMO℠	MyBlue HMO℠	Blue Preferred PPO℠
HSA Eligible	No	No	No
Outpatient Prescription Drugs - Preferred Pharmacy [6]	$15 / $25 / 30% / 45% / 50% / 55% [7]	$15 / $30 / $60 / $250 [8]	$0 / $10 / 20% / 35% / 45% / 50% [7]
Outpatient Prescription Drugs - Non-Preferred Pharmacy [6]	$25 / $35 / 35% / 45% / 50% / 55% [7]	$15 / $30 / $60 / $250 [8]	$10 / $20 / 25% / 40% / 45% / 50% [7]
Prescription Drug Benefit Utilization Management Programs [9]	**Specialty Pharmacy Program:** To be eligible for maximum benefits, specialty medications must be obtained through an in-network Specialty Pharmacy provider. **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 receive authorization from BCBSOK. 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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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 benefit coverage starts after annual medical deductible has been met. Retail stores in the Preferred Pharmacy Network offer members prescriptions with a lower possible copay amount.
7 Six prescription drug payment level tiers: Preferred Generic / Non-Preferred Generic / Preferred Brand / Non-Preferred Brand / Preferred Specialty / Non-Preferred Specialty.
8 Four prescription drug payment level tiers: Generic / Preferred Brand / Non-Preferred Brand / Specialty. Costs are for outpatient prescriptions through a preferred pharmacy. Deductible may apply to certain tiers. See your Summary of Benefits and Coverage for details.
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.

BlueCross BlueShield of Oklahoma

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
Attn: Office of Civil Rights Coordinator
300 E. Randolph St., 35th Floor
Chicago, IL 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
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
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal:
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 bcbsok.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.

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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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