




The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.bcbsmt.com](http://www.bcbsmt.com) or by calling 1-888-901-4989. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](http://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?	<u>In-Network</u> : \$1,000 Individual <u>Out-of-Network</u> : \$1,500 Individual	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Services with a <u>copayment</u> , and preventive health are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	<u>Medical In-Network</u> : \$4,000 Individual / \$8,000 Family <u>Medical Out-of-Network</u> : \$4,950 Individual / \$10,900 Family <u>Pharmacy</u> : \$1,800 Individual / \$3,600 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billed</u> charges and health care this <u>plan</u> doesn't cover. Non-Preferred (Tier 3) brand and Non-Preferred specialty (Tier 4) products do not accrue towards the pharmacy <u>out-of-pocket maximum</u> .	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See <a href="http://www.bcbsmt.com">www.bcbsmt.com</a> or call 1-888-901-4989 for a list of participating <u>providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$25/visit; <u>deductible</u> does not apply	35% <u>coinsurance</u>	<u>Copayment</u> applies only for evaluation and management. Additional charges are subject to <u>deductible</u> and <u>coinsurance</u> .
	<u>Specialist</u> visit	\$35/visit; <u>deductible</u> does not apply	35% <u>coinsurance</u>	<u>Copayment</u> applies only for evaluation and management. Additional charges are subject to <u>deductible</u> and <u>coinsurance</u> .
	<u>Preventive care/screening/immunization</u>	No Charge; <u>deductible</u> does not apply	35% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Predetermination review is strongly recommended; see your plan document* for details.
	Imaging (CT/PET scans, MRIs)	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Predetermination review is strongly recommended; see your plan document* for details.

\* For more information about limitations and exceptions, see the plan or policy document at [benefits.mt.gov](https://benefits.mt.gov)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://benefits.mt.gov">benefits.mt.gov</a> or call 1-866-333-2757 for Commercial members or 1-866-270-3877 for Medicare RX members.</p>	\$0 Preventive products	No Charge (certain preventive care and select medications).	No Charge (certain preventive care and select medications), limited to a 10 day supply.	Charges payable through the Plan's Pharmacy Benefit Manager (PBM) program, Navitus.
	Tier 1 Preferred generics and some lower cost brand products	\$15 copayment retail 1-34 day supply, \$30 copayment retail 35-90 day supply, \$30 copayment mail order up to 90 day supply.	\$15 copayment retail, limited to a 10 day supply.	If generic is available and chosen over brand, regardless of how prescription is written, member is responsible for the difference in cost plus applicable brand copayment.
	Tier 2 Preferred brand products and some high cost non-preferred generics	\$50 copayment retail 1-34 day supply, \$100 copayment retail 35-90 day supply, \$100 copayment mail order up to 90 day supply.	\$50 copayment retail, limited to a 10 day supply.	Fills provided by a non-preferred pharmacy are limited to 10 day supply.  Certain prescriptions require prior approval before the drug can be authorized for coverage.
	Tier 3 Non-preferred products (may include some high cost non-preferred generics)	50% coinsurance retail or mail order up to 90 day supply.	50% coinsurance retail, limited to a 10 day supply.	Tier 3 Non-Preferred brand prescriptions do not accrue towards the pharmacy out-of-pocket maximum.
	Tier 4 Specialty products	\$200 copayment Preferred Specialty Pharmacy.	50% coinsurance Non-Preferred Specialty Pharmacy or retail.	Specialty prescriptions should be obtained from a specialty pharmacy. Specialty prescriptions are limited to a 34 day supply. Non-Preferred Specialty prescriptions do not accrue toward the pharmacy out-of-pocket maximum. A \$50 copayment will apply to Preferred Specialty Pharmacy products for Medicare retirees only.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [benefits.mt.gov](http://benefits.mt.gov)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Predetermination review is strongly recommended; see your plan document* for details.
	Physician/surgeon fees	25% <u>coinsurance</u>	35% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	Predetermination review is strongly recommended; see your plan document* for details.
	<u>Urgent care</u>	\$35/visit; <u>deductible</u> does not apply	35% <u>coinsurance</u>	Ancillary charges are subject to <u>deductible</u> and <u>coinsurance</u> .
If you have a hospital stay	Facility fee (e.g., hospital room)	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Predetermination review is strongly recommended.
	Physician/surgeon fees	25% <u>coinsurance</u>	35% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25/office visit; <u>deductible</u> does not apply 25% <u>coinsurance</u> for other outpatient services	35% <u>coinsurance</u>	Predetermination review is strongly recommended; see your plan document* for details.
	Inpatient services	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Predetermination review is strongly recommended. Residential treatment facilities will be covered if medical necessity criteria are met.
If you are pregnant	Office visits	\$25 Primary Care/\$35 Specialist; <u>deductible</u> does not apply	35% <u>coinsurance</u>	<u>Copayment</u> applies to first prenatal visit (per pregnancy). <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Predetermination review is strongly recommended.
	Childbirth/delivery professional services	25% <u>coinsurance</u>	35% <u>coinsurance</u>	
	Childbirth/delivery facility services	25% <u>coinsurance</u>	35% <u>coinsurance</u>	

\* For more information about limitations and exceptions, see the plan or policy document at [benefits.mt.gov](https://benefits.mt.gov)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Predetermination review is strongly recommended. 70 visit maximum per benefit period.
	<u>Rehabilitation services</u>	\$25/visit; <u>deductible</u> does not apply	35% <u>coinsurance</u>	Predetermination review is strongly recommended. <u>Deductible</u> and <u>coinsurance</u> apply to other therapy services.
	<u>Habilitation services</u>	\$25/visit; <u>deductible</u> does not apply	35% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Predetermination review is strongly recommended. 70 days maximum per benefit period.
	<u>Durable medical equipment</u>	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Predetermination review is strongly recommended for items \$2,500 and over.
	<u>Hospice services</u>	25% <u>coinsurance</u>	35% <u>coinsurance</u>	Predetermination review is strongly recommended. Includes bereavement counseling.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

**Excluded Services & Other Covered Services:**

<b>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</b>		
<ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Cosmetic surgery (except for correction of congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases)</li> <li>• Dental care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Long term care</li> <li>• Routine eye care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Routine foot care (except for individuals with co-morbidities, such as diabetes)</li> <li>• Weight loss programs (except preventive services)</li> </ul>

<b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)</b>		
<ul style="list-style-type: none"> <li>• Acupuncture (20 visit maximum combined with Chiropractic per benefit period)</li> <li>• Chiropractic care (20 visit maximum combined with Acupuncture per benefit period)</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids (for dependent children under age 19, and <u>medically necessary</u> cochlear implants, per medical policy)</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> </ul>

\* For more information about limitations and exceptions, see the plan or policy document at [benefits.mt.gov](https://benefits.mt.gov)

**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 1-888-901-4989, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](http://www.cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://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 on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Blue Cross and Blue Shield of Montana at 1-888-901-4898, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or the Montana Commissioner of Securities and Insurance at 1-406-444-2040 or 1-800-332-6148. Additionally, a consumer assistance program can help you file your [appeal](#). Contact the Montana Consumer Assistance Program at 1-800-332-6148 or visit [www.csi.mt.gov](http://www.csi.mt.gov).

#### **Does this plan provide Minimum Essential Coverage? Yes**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

#### **Does this plan meet the Minimum Value Standards? 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 1-888-901-4898.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-901-4898.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-888-901-4898.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-901-4898.

*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 <u>plan's overall deductible</u>	\$1,000
■ <u>Specialist copayment</u>	\$35
■ Hospital (facility) <u>coinsurance</u>	25%
■ Other <u>coinsurance</u>	25%

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$40
<u>Coinsurance</u>	\$2,900
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,000</b>

### Managing Joe's Type 2 Diabetes

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

■ The <u>plan's overall deductible</u>	\$1,000
■ <u>Specialist copayment</u>	\$35
■ Hospital (facility) <u>coinsurance</u>	25%
■ Other <u>coinsurance</u>	25%

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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$900
<u>Copayments</u>	\$800
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,720</b>

### Mia's Simple Fracture

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

■ The <u>plan's overall deductible</u>	\$1,000
■ <u>Specialist copayment</u>	\$35
■ Hospital (facility) <u>coinsurance</u>	25%
■ Other <u>coinsurance</u>	25%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,500</b>

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



BlueCross BlueShield of Montana

**Health care coverage is important for everyone.**

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability.

To receive language or communication 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, contact us to file a grievance.

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

Phone: 855-664-7270 (voicemail)  
TTY/TDD: 855-661-6965  
Fax: 855-661-6960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services  
200 Independence Avenue SW  
Room 509F, HHH Building 1019  
Washington, DC 20201

Phone: 800-368-1019  
TTY/TDD: 800-537-7697  
Complaint Portal: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>  
Complaint Forms: <http://www.hhs.gov/ocr/office/file/index.html>





## BlueCross BlueShield of Montana

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost.  
To talk to an interpreter, call 855-710-6984.

Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
العربية Arabic	إن كان لديك أو لدى شخص تساعد أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم فوري، اتصل بلع الرمز 855-710-6984.
繁體中文 Chinese	如果您，或您正在協助的對象，對此有疑問，您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員，請撥電話 號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાયદેમુબાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કોલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपके अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनवादक से बात करने के लिए 855-710-6984 पर कॉल करें।
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éi doodago la'da biká anánilwo'ígíí, na'ídiłkidgo, ts'ídá bee ná ahóótí'i' t'áá níik'e níká a'doolwoł dóó bina'ídiłkidgíí bee níł h odoonih. Ata'dahalne'ígíí bich`j' hodiilnih kwe`é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سوالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiegokolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کر رہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں منہمدمد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.