



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, call 1-855-270-2327 or visit us at [lacare.org](http://lacare.org). 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 [healthcare.gov/sbc-glossary](http://healthcare.gov/sbc-glossary) or call 1-855-270-2327 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>\$5,800 individual / \$11,600 family.</b> Per calendar year	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of deductible expenses paid by all family members meets the overall family <a href="#">deductible</a>
Are there services covered before you meet your <a href="#">deductible</a> ?	<b>Yes.</b> Family, physician, and specialist office visits, <a href="#">preventive care</a> , and other services not subject to <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount, but a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without cost sharing and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	<b>\$450 individual / \$900 family</b> for <a href="#">prescription drug coverage</a> . There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>\$8,850 individual / \$17,700 family.</b> Per calendar year For <a href="#">participating providers</a>	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance billing</a> and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limits</a>
Will you pay less if you use a <a href="#">network provider</a> ?	<b>Yes.</b> See <a href="http://lacare.org">lacare.org</a> or call 1-855-270-2327 (TTY 711) for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a participating <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">non-participating provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">participating provider</a> might use a <a href="#">non-participating provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services..
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	<b>Yes.</b>	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a>

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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 <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$60 <a href="#">copay</a> / visit	Not covered	None
	<a href="#">Specialist</a> visit	\$95 <a href="#">copay</a> / visit	Not covered	Subject to <a href="#">deductible</a> after 1st 3 non-preventive visits. <a href="#">Referral</a> is required *
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$40 <a href="#">copay</a> / test for laboratory tests. 40% <a href="#">coinsurance</a> / test for X-rays diagnostic imaging and ultrasounds.	Not covered	X-rays, diagnostic imaging, and ultrasounds are subject to <a href="#">deductible</a> *
	Imaging (CT/PET scans, MRIs)	40% <a href="#">coinsurance</a>	Not covered	<a href="#">Prior Authorization</a> is Required Subject to <a href="#">deductible</a> *
<b>If you need drugs to treat your illness or condition</b>  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.lacare.org/members/getting-care/pharmacy-services">http://www.lacare.org/members/getting-care/pharmacy-services</a>	Tier 1 - Most Generics	Retail - \$19 <a href="#">copay</a> / script Mail Order - \$38 <a href="#">copay</a> / script	Not covered	Up to 30-day supply for Retail Pharmacy Up to 90-day supply for Mail Service Pharmacy <a href="#">Prior Authorization</a> is Required.
	Tier 2 -Preferred brand drugs	Retail – 40% <a href="#">coinsurance</a> / script Mail service – 40% <a href="#">coinsurance</a> / script	Not covered	Up to 30-day supply for Retail Pharmacy Up to 90-day supply for Mail Service Pharmacy Subject to pharmacy <a href="#">deductible</a> up to \$500 maximum per script *

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [lacare.org](#).

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)	
	Tier 3 - Non-preferred brand drugs	Retail – 40% <a href="#">coinsurance</a> / script Mail service – 40% <a href="#">coinsurance</a> / script	Not covered	Up to 30-day supply for Retail Pharmacy Up to 90-day supply for Mail Service Pharmacy Subject to pharmacy <a href="#">deductible</a> up to \$500 maximum per script *
	Tier 4 - <a href="#">Specialty drugs</a>	40% <a href="#">coinsurance</a> / script	Not covered	<a href="#">Prior Authorization</a> is required. Not available through Mail Service. Subject to pharmacy <a href="#">deductible</a> up to \$500 maximum per script *
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% <a href="#">coinsurance</a>	Not covered	<a href="#">Prior Authorization</a> is Required. Subject to <a href="#">deductible</a> *
	Physician / surgeon fees	40% <a href="#">coinsurance</a>	Not covered	Subject to <a href="#">deductible</a> *
	Outpatient visit	40% <a href="#">coinsurance</a>	Not covered	Subject to <a href="#">deductible</a> *
If you need immediate medical attention	<a href="#">Emergency room care</a>	40% <a href="#">coinsurance</a> Physician fee – no charge	40% <a href="#">coinsurance</a> Physician fee – no charge	<a href="#">Copay</a> waived if admitted. Subject to <a href="#">deductible</a> *
	<a href="#">Emergency medical transportation</a>	40% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Subject to <a href="#">deductible</a> *
	<a href="#">Urgent care</a>	\$60 <a href="#">copay</a> / visit	\$60 / visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	40% <a href="#">coinsurance</a>	Not covered	<a href="#">Prior Authorization</a> is Required. Subject to <a href="#">deductible</a> *
	Physician/surgeon fees	40% <a href="#">coinsurance</a>	Not covered	Subject to <a href="#">deductible</a> *
If you need mental health, behavioral health, or substance	Outpatient services	\$60 <a href="#">copay</a> / office visit 40% <a href="#">coinsurance</a> up to <a href="#">\$60 copay for other outpatient services*</a>	Not covered	<a href="#">Prior Authorization</a> is Required for Psychological Testing. *

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [lacare.org](#).

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>abuse services</b>	Inpatient services	40% <a href="#">coinsurance</a>	Not covered	Prior Authorization is Required. Subject to <a href="#">deductible</a> *
<b>If you are pregnant</b>	Office visits	No charge	Not covered	For prenatal care and preconception visits
	Childbirth/delivery professional services	40% <a href="#">coinsurance</a>	Not covered	Subject to deductible
	Childbirth/delivery facility services	40% <a href="#">coinsurance</a>	Not covered	Subject to deductible *
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	40% <a href="#">coinsurance</a> / visit	Not covered	Up to a maximum of 100 visits per Calendar Year per Member by home health care agency providers. <a href="#">Prior Authorization</a> is Required. Subject to <a href="#">deductible</a> *
	<a href="#">Rehabilitation services</a>	\$60 <a href="#">copay</a> / visit	Not covered	<a href="#">Prior Authorization</a> is Required.*
	<a href="#">Habilitation services</a>	\$60 <a href="#">copay</a> / visit	Not covered	<a href="#">Prior Authorization</a> is Required. *
	<a href="#">Skilled nursing care</a>	40% <a href="#">coinsurance</a>	Not covered	Up to a maximum of 100 days per Calendar Year per Member. <a href="#">Prior Authorization</a> is Required. Subject to <a href="#">deductible</a> *
	<a href="#">Durable medical equipment</a>	40% <a href="#">coinsurance</a>	Not covered	<a href="#">Prior Authorization</a> is Required. Subject to <a href="#">deductible</a> *
	<a href="#">Hospice services</a>	No charge	Not covered	<a href="#">Prior Authorization</a> is Required. *
<b>If your child needs dental or eye care</b>	Children's Eye exam	No charge	Not covered	1 visit per calendar year
	Children's Glasses	No charge	Not covered	1 pair of glasses per year (or contact lenses in lieu of glasses).
	Children's Dental check-up	No Charge	Not covered	Oral exam and preventive cleaning limited to 1 every 6 months. See your <a href="#">plan</a> document for additional information about services.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [lacare.org](#).

### 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](#).)

- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Weight loss programs

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

- Acupuncture
- Bariatric surgery
- Medical necessary routine foot care
- Services related to Abortion

## 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: Department of Managed Health Care at **1 (888) HMO-2219 (1-888-466-2219)** or [hmohelp.ca.gov](http://hmohelp.ca.gov); U.S. Department of Health and Human Services at **1-877-267-2323 x61565** or [www.cciio.cms.gov](http://www.cciio.cms.gov); Covered California at **1 (800) 300-1506** or [coveredca.com](http://coveredca.com); or contact L.A. Care Health Plan at **1- 855-270-2327**. We are available 24 hours a day, 7 days a week, including holidays. 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 contact your rights, this notice, or assistance, contact L.A. Care Customer Service at **1- 855-270-2327**. We are available 24 hours a day, 7 days a week, including holidays. Additionally, you can contact the California DMHC at **1-888-466-2219** or visit [dmhc.ca.gov](http://dmhc.ca.gov).

## Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through Covered California 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 Covered California

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **1- 855-270-2327**.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1- 855-270-2327**

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 **1- 855-270-2327**

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijijigo holne' **1- 855-270-2327**

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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 [deductible](#) \$5,800
- [Specialist \[cost sharing\]](#) \$95
- Hospital (facility) [\[cost sharing\]](#) 40%
- Other [\[cost sharing\]](#) 40%

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>	
<a href="#">Deductibles</a>	\$5,800
<a href="#">Copayments</a>	\$500
<a href="#">Coinsurance</a>	\$2,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$8,560</b>

**Managing Joe's Type 2 Diabetes**

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

- The [plan's](#) overall [deductible](#) \$5,800
- [Specialist \[cost sharing\]](#) \$95
- Hospital (facility) [\[cost sharing\]](#) 40%
- Other [\[cost sharing\]](#) 40%

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>	
<a href="#">Deductibles</a>	\$2,300
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$3,720</b>

**Mia's Simple Fracture**

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

- The [plan's](#) overall [deductible](#) \$5,800
- [Specialist \[cost sharing\]](#) \$95
- Hospital (facility) [\[cost sharing\]](#) 40%
- Other [\[cost sharing\]](#) 40%

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>	
<a href="#">Deductibles</a>	\$2,400
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,400</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

## Language Assistance

### English Tagline

ATTENTION: If you need help in your language call **1-855-270-2327** (TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call **1-855-270-2327** (TTY: 711). These services are free of charge.

### الشعار بالعربية (Arabic)

يُرجى الانتباه: إذا احتجت إلى المساعدة بلغتك، فاتصل بـ **1-855-270-2327** (TTY: 711). تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة بريـل والخط الكبير. اتصل بـ **1-855-270-2327** (TTY: 711). هذه الخدمات مجانية.

### Հայերեն պիտակ (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե Ձեզ օգնություն է հարկավոր Ձեր լեզվով, զանգահարեք **1-855-270-2327** (TTY: 711): Կան նաև օժանդակ միջոցներ ու ծառայություններ հաշմանդամություն ունեցող անձանց համար, օրինակ՝ Բրայլի գրատիպով ու խոշորատառ տպագրված նյութեր: Չանգահարեք **1-855-270-2327** (TTY: 711): Այդ ծառայություններն անվճար են:

### ប្រាសាទសំខ្មែរ (Cambodian)

ចំណាំ: បើអ្នក ត្រូវ ការជំនួយ ជាភាសា របស់អ្នក សូម ទូរស័ព្ទទៅលេខ **1-855-270-2327** (TTY: 711)។ ជំនួយ និង សេវាកម្ម សម្រាប់ ជនពិការ ដូចជាឯកសារសរសេរជាអក្សរធំ សម្រាប់ជនពិការភ្នែក ឬឯកសារសរសេរជាអក្សរពុម្ពធំ ក៏អាចរកបានផងដែរ។ ទូរស័ព្ទមកលេខ **1-855-270-2327** (TTY: 711)។ សេវាកម្មទាំងនេះ មិនគិតថ្លៃឡើយ។

### 简体中文标语 (Chinese)

请注意：如果您需要以您的母语提供帮助，请致电 **1-855-270-2327** (TTY: 711)。另外还提供针对残疾人士的帮助和服务，例如盲文和需要较大字体阅读，也是方便取用的。请致电 **1-855-270-2327** (TTY: 711)。这些服务都是免费的。

### فارسی زبان به مطلب (Farsi)

توجه: اگر می‌خواهید به زبان خود کمک دریافت کنید، با **1-855-270-2327** (TTY: 711) تماس بگیرید. کمک‌ها و خدمات مخصوص افراد دارای معلولیت، مانند نسخه‌های خط بریل و چاپ با حروف بزرگ، نیز موجود است. با **1-855-270-2327** (TTY: 711) تماس بگیرید. این خدمات رایگان ارائه می‌شوند.

### हिंदी टैगलाइन (Hindi)

ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है तो **1-855-270-2327** (TTY: 711) पर कॉल करें। अशक्तता वाले लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में भी दस्तावेज़ उपलब्ध हैं। **1-855-270-2327** (TTY: 711) पर कॉल करें। ये सेवाएं नि: शुल्क हैं।

### Nqe Lus Hmoob Cob (Hmong)

CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu rau **1-855-270-2327** (TTY: 711). Muaj cov kev pab txhawb thiab kev pab cuam rau cov neeg xiam oob qhab, xws li puav leej muaj ua cov ntawv su thiab luam tawm ua tus ntawv loj. Hu rau **1-855-270-2327** (TTY: 711). Cov kev pab cuam no yog pab dawb xwb.



### **日本語表記 (Japanese)**

注意日本語での対応が必要な場合は **1-855-270-2327 (TTY: 711)** へお電話ください。点字の資料や文字の拡大表示など、障がいをお持ちの方のためのサービスも用意しています。 **1-855-270-2327 (TTY: 711)** へお電話ください。これらのサービスは無料で提供しています。

### **한국어 태그라인 (Korean)**

유의사항: 귀하의 언어로 도움을 받고 싶으시면 **1-855-270-2327 (TTY: 711)** 번으로 문의하십시오. 점자나 큰 활자로 된 문서와 같이 장애가 있는 분들을 위한 도움과 서비스도 이용 가능합니다. **1-855-270-2327 (TTY: 711)** 번으로 문의하십시오. 이러한 서비스는 무료로 제공됩니다.

### **ਪੰਜਾਬੀ ਟੈਗਲਾਈਨ (Punjabi)**

ਪਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਾਲ ਕਰੋ **1-855-270-2327 (TTY: 711)**. ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਮੋਟੀ ਛਪਾਈ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ। ਕਾਲ ਕਰੋ **1-855-270-2327 (TTY: 711)**. ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ।

### **Русский слоган (Russian)**

ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру **1-855-270-2327 (TTY: 711)**. Также предоставляются средства и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру **1-855-270-2327 (TTY: 711)**. Такие услуги предоставляются бесплатно.

### **Mensaje en español (Spanish)**

ATENCIÓN: si necesita ayuda en su idioma, llame al **1-855-270-2327 (TTY: 711)**. También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al **1-855-270-2327 (TTY: 711)**. Estos servicios son gratuitos.

### **Tagalog Tagline (Tagalog)**

ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa **1-855-270-2327 (TTY: 711)**. Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan, tulad ng mga dokumento sa braille at malaking print. Tumawag sa **1-855-270-2327 (TTY: 711)**. Libre ang mga serbisyonang ito.

### **แท็กไลน์ภาษาไทย (Thai)**

โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข **1-855-270-2327 (TTY: 711)** นอกจากนี้ ยังพร้อมให้ความช่วยเหลือและบริการต่าง ๆ สำหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่ กรุณาโทรศัพท์ไปที่หมายเลข **1-855-270-2327 (TTY: 711)** ไม่มีค่าใช้จ่ายสำหรับบริการเหล่านี้

### **Khẩu hiệu tiếng Việt (Vietnamese)**

CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số **1-855-270-2327 (TTY: 711)**. Chúng tôi cũng hỗ trợ và cung cấp các dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và chữ khổ lớn (chữ hoa). Vui lòng gọi số **1-855-270-2327 (TTY: 711)**. Các dịch vụ này đều miễn phí.