

\$20 PCP/\$20 Specialist copayment, \$100 Ancillary deductible, 20% coinsurance

Pharmacy: \$5 copayment/\$20 copayment/\$45 copayment

**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay for Covered Services


**Coverage Period Begins:** 01-01-2026  
**Coverage For:** VSTRS **Plan Type:** Indemnity



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, [www.vehi.org/vstrs-health-plan-information](http://www.vehi.org/vstrs-health-plan-information). 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 (800) 255-4550 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$0 individual / \$0 family.	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers. We apply any portion of your <a href="#">deductible</a> that you pay for services occurring after September 30 each <a href="#">plan</a> year towards your next year's <a href="#">deductible</a> as well. Your plan year: 01-01-2026 through 12-31-2026.
Are there services covered before you meet your <a href="#">deductible</a> ?	Not applicable.	Not applicable.
Are there other <a href="#">deductibles</a> for specific services?	Yes. \$100 individual up to a maximum of three member <a href="#">deductibles</a> per family for emergency medical transport, <a href="#">durable medical equipment</a> and supplies, and private duty nursing.	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> ?	Major medical: \$600 per member. Combined <a href="#">out-of-pocket limit</a> for services such as emergency medical transport, <a href="#">durable medical equipment</a> and supplies, and private duty nursing. <a href="#">Prescription drugs</a> : \$600 individual / \$1,200 family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a <a href="#">plan</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="#">Copayments</a> on certain services, premiums, <a href="#">balance-billing</a> charges, 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 limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.bluecrossvt.org/find-doctor">www.bluecrossvt.org/find-doctor</a> or call (800) 255-4550 for a list of <a href="#">network</a> providers.	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network 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="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). For certain <a href="#">emergency services</a> and/or services at an in-network hospital or surgical center (as explained below), the maximum amount you may pay is the <a href="#">plan's</a> in <a href="#">network cost-sharing</a> amount. In these circumstances, the providers cannot balance bill you. Check with your <a href="#">provider</a> before you get services.

Important Questions	Answers	Why This Matters:
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider</a>'s office or clinic</b>	Primary care visit to treat an injury or illness	\$20 <a href="#">copayment</a> per visit for <a href="#">primary care physician</a> and mental health / substance use	\$20 <a href="#">copayment</a> per visit for <a href="#">primary care physician</a> and mental health / substance use	Some services require <a href="#">prior approval</a> . For clarification on mental health services visit <a href="http://www.bluecrossvt.org/members/coverage">www.bluecrossvt.org/members/coverage</a> .
	<a href="#">Specialist</a> visit	\$20 <a href="#">copayment</a> per visit	\$20 <a href="#">copayment</a> per visit	Some services require <a href="#">prior approval</a> .
	Other practitioner office visit	\$20 <a href="#">copayment</a> per visit for chiropractic care and nutritional counseling; no charge for outpatient physical, speech and occupational therapy	No charge for outpatient physical, speech and occupational therapy; chiropractic care and nutritional counseling not covered	Some services require <a href="#">prior approval</a> . Outpatient physical, speech and occupational therapy benefits are covered up to 30 visits combined.
	<a href="#">Preventive care</a> / <a href="#">Screening</a> /immunization	\$20 <a href="#">copayment</a> per visit	\$20 <a href="#">copayment</a> per visit	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. For clarification on <a href="#">preventive services</a> visit <a href="http://www.bluecrossvt.org/members/coverage">www.bluecrossvt.org/members/coverage</a> .
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge for office based and outpatient hospital	No charge for office based and outpatient hospital	Some services require <a href="#">prior approval</a> .
	Imaging (CT/PET scans, MRIs)	No charge	No charge	Most services require <a href="#">prior approval</a> .

\*Deductible applies to these services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="http://www.bluecrossvt.org/pharmacies-medications">prescription drug coverage</a> is available at <a href="http://www.bluecrossvt.org/pharmacies-medications">www.bluecrossvt.org/pharmacies-medications</a> . This plan follows the National Performance Formulary (NPF).	Generic drugs	\$5 <a href="#">copayment</a> / \$15 <a href="#">copayment</a>	Not covered	Up to a 30-day supply / 90-day supply for most prescription drugs. Some prescriptions require prior approval. All generic and brand diabetic prescription drugs and diabetic supplies when obtained through your prescription drug benefit are covered at 100%.
	Preferred brand drugs	\$20 <a href="#">copayment</a> / \$60 <a href="#">copayment</a>	Not covered	Up to a 30-day supply / 90-day supply for most prescription drugs. Some prescriptions require prior approval.
	Non-preferred brand drugs	\$45 <a href="#">copayment</a> / \$135 <a href="#">copayment</a>	Not covered	Up to a 30-day supply / 90-day supply for most prescription drugs. Some prescriptions require prior approval.
	Wellness drugs	Wellness prescription drugs process the same as any other prescription.	Not covered	Up to a 30-day supply / 90-day supply for most prescription drugs. Some prescriptions require prior approval.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge	No charge	Some services require <a href="#">prior approval</a> . If you see an <a href="#">out-of-network provider</a> at an in-network facility, the most the <a href="#">provider</a> may bill you is the in-network <a href="#">cost-sharing</a> amount.
	Physician/surgeon fees	No charge	No charge	Some services require <a href="#">prior approval</a> . If you see an <a href="#">out-of-network provider</a> at an in-network facility, the most the <a href="#">provider</a> may bill you is the in-network <a href="#">cost-sharing</a> amount.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	No charge for facility services; \$20 <a href="#">copayment</a> per visit for physician services	No charge for facility services; \$20 <a href="#">copayment</a> per visit for physician services	Must meet emergency criteria. <a href="#">Copayment</a> waived if admitted. If you have an emergency medical condition, and get emergency services from an <a href="#">out-of-network provider</a> or facility, the maximum you may pay is the standard in-network <a href="#">cost-sharing</a> amount and you cannot be balance billed.

\*Deductible applies to these services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	<a href="#">Emergency medical transportation</a>	\$100 individual / \$300 family deductible, then 20% <a href="#">coinsurance</a>	\$100 individual / \$300 family deductible, then 20% <a href="#">coinsurance</a>	Must meet emergency criteria. If you have an emergency medical condition, and get emergency services from an <a href="#">out-of-network provider</a> or facility, the maximum you may pay is the standard in-network <a href="#">cost-sharing</a> amount and you cannot be balance billed.
	<a href="#">Urgent care</a>	\$20 <a href="#">copayment</a> per visit	\$20 <a href="#">copayment</a> per visit	Applies to urgent care facilities. If you have an emergency medical condition, and get emergency services from an <a href="#">out-of-network provider</a> or facility, the maximum you may pay is the standard in-network <a href="#">cost-sharing</a> amount and you cannot be balance billed.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	No charge	Out-of-state inpatient care requires prior approval. If you receive care from an out-of-network provider at an in-network hospital or ambulatory surgical center, the most the provider may bill you is the in-network cost-sharing amount and the provider cannot balance bill you.
	Physician/surgeon fees	No charge	No charge	Some services require <a href="#">prior approval</a> . If you receive care from an <a href="#">out-of-network provider</a> at an in-network hospital or ambulatory surgical center, the most the <a href="#">provider</a> may bill you is the in-network <a href="#">cost-sharing</a> amount and the <a href="#">provider</a> cannot balance bill you.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	No charge	Some services require <a href="#">prior approval</a> .
	Inpatient services	No charge	No charge	Includes facility and physician fees. Requires <a href="#">prior approval</a> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you are pregnant	Office visits	No charge	No charge	Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.). For a list of services visit <a href="http://www.bluecrossvt.org/members/coverage">www.bluecrossvt.org/members/coverage</a> .
	Childbirth/delivery professional services	No charge	No charge	Out-of-state inpatient care requires <a href="#">prior approval</a> .
	Childbirth/delivery facility services	No charge	No charge	Out-of-state inpatient care requires <a href="#">prior approval</a> .
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge for home health care; \$100 individual / \$300 family deductible, then 20% <a href="#">coinsurance</a> for private duty nursing	No charge for home health care; \$100 individual / \$300 family deductible, then 20% <a href="#">coinsurance</a> for private duty nursing	Home infusion therapy requires <a href="#">prior approval</a> . Outpatient physical, speech and occupational therapy benefits are covered up to 30 visits combined.
	<a href="#">Rehabilitation services</a>	No charge inpatient; no charge cardiac / pulmonary services	No charge inpatient; cardiac / pulmonary services not covered	Inpatient rehabilitation services require <a href="#">prior approval</a> .
	<a href="#">Habilitation services</a>	No charge for inpatient services	No charge for inpatient services	Requires <a href="#">prior approval</a> . Outpatient physical, speech and occupational therapy benefits are covered up to 30 visits combined.
	<a href="#">Skilled nursing care</a> (facility)	No charge	Not covered	Requires <a href="#">prior approval</a> .
	<a href="#">Durable medical equipment</a> (including supplies)	\$100 individual / \$300 family deductible, then 20% <a href="#">coinsurance</a>	\$100 individual / \$300 family deductible, then 20% <a href="#">coinsurance</a>	May require <a href="#">prior approval</a> . Diabetic supplies and <a href="#">durable medical equipment</a> obtained at a <a href="#">durable medical equipment</a> supplier are covered at 100%.
	<a href="#">Hospice services</a>	No charge	No charge	None
If your child needs dental or eye care	Eye exam	Not covered	Not covered	None
	Glasses	Not covered	Not covered	None
	Dental check-up	Not covered	Not covered	None

\*Deductible applies to these services.

## 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](#).)

- |  |                                 |                            |
|--|---------------------------------|----------------------------|
| • Acupuncture  | • Dental care (child and adult) | • Routine eye care         |
| • Cosmetic Surgery (except with prior approval for reconstruction) | • Infertility Medications       | • Sexual dysfunction drugs |
|  | • Long-term care                | • Weight loss programs     |

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

- |   |   |   |
|---|---|---|
| • Abortion  | • Hearing aids (covered up to one per ear every three years)  | • Private-duty nursing (covered up to 14 hours per <a href="#">plan</a> year) |
| • Bariatric surgery   | • Non-emergency care when traveling outside the U.S. ( <a href="http://www.bluecrossvt.org/members/coverage">www.bluecrossvt.org/members/coverage</a> ) | • Routine foot care   |
| • Chiropractic care (requires prior approval after 12 visits) |   |   |

## 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 Labor's Employee Benefits Security Administration at (866) 444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or the Department of Health and Human Services at (877) 267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). You may also contact the [plan](#) at (800) 247-2583. 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 (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: (800) 255-4550.

## 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](#).

—————To see examples of how this plan might cover costs for a sample medical situation, see the next page.—————

## 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 prenatal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$20
■ Hospital (facility)	\$0
■ Other	\$0

his **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>
---------------------------	-----------------

In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$50
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$110</b>

### Managing Joe's Type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$20
■ Hospital (facility)	\$0
■ Other	\$0

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>
---------------------------	----------------

In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$200
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$620</b>

### Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$20
■ Hospital (facility)	\$0
■ Other	\$0

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>
---------------------------	----------------

In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$200
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$300</b>

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

Custom Summary Name: BCBS-J plan-x-600-20%-STK-20-20-x-x-x-x-GF-LARG|BCBS-Rx-0-600-x-5-20-45-3-x-GF-2026

000952166 80-0270HCCSSG1-1-22 (9/21)



# DISCLAIMERS

## General Exclusions

While your health plan covers a broad array of necessary services and supplies, it doesn't cover every possible medical expense. If you would like to review the list of general exclusions before enrolling, visit [bluecrossvt.org/contracts](https://bluecrossvt.org/contracts), click on the plan in which you are enrolling and read the chapter entitled "General Exclusions." Once you enroll, you will receive an Outline of Coverage and a link to your Certificate of Coverage. Please read both carefully as they govern your specific benefits.

## How We Protect Your Privacy

The law requires us to maintain the privacy of your health information by using or disclosing it only with your authorization or as otherwise allowed by law. You may find information about our privacy practices at [bluecrossvt.org/privacypolicies](https://bluecrossvt.org/privacypolicies).

## NOTICE: Discrimination is Against the Law

Blue Cross® and Blue Shield® of Vermont (Blue Cross VT) and its affiliate The Vermont Health Plan (TVHP) comply with applicable federal and state civil rights laws and do not discriminate, exclude people or treat them differently on the basis of race, color, national origin, age, disability, gender identity or sex, ethnicity, sexual orientation, or HIV-status.

Blue Cross VT provides free aids and services to people with disabilities to communicate effectively with us. We provide qualified sign language interpreters and written information in other formats (e.g., large print, audio or accessible electronic format).

Blue Cross VT provides free language services to people whose primary language is not English. We provide qualified interpreters and information written in other languages.

If you need these services, contact [civilrightscordinator@bcbsvt.com](mailto:civilrightscordinator@bcbsvt.com).

If you believe that Blue Cross VT has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, gender identity or sex, ethnicity, sexual orientation, or HIV-Status, you can file a grievance with: Whitney Standefer-Smith, Civil Rights Coordinator, P.O. Box 186, Montpelier, VT 05601-0186, call (800) 247-2583 (TTY/TDD: 711), fax (802) 229-0511, or email Whitney Standefer-Smith at [civilrightscordinator@bcbsvt.com](mailto:civilrightscordinator@bcbsvt.com). You can file a grievance in person, by mail, via fax, or by email. If you need help filing a grievance, Whitney Standefer-Smith, Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically or through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW Room 509F  
HHH Building Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <https://www.hhs.gov/ocr/complaints/index.html>

**For free language-assistance service, call (800) 247-2583 (TTY/TDD: 711).**



ARABIC	للحصول على خدمات المساعدة اللغوية المجانية ، اتصل (800) 247 2583 (TTY/TDD: 711). lilhusul ealaa khadmat almusaeadat allughawiat almajaaniat, atasal (800) 247-2583 (TTY/TDD: 711).
CHINESE	如需免費語言支援服務，請致電 (800) 247-2583 TTY/TDD: 711).
CUSHITE (OROMO)	Tajaajila gargaarsa afaanii bilisaa argachuuf, (800) 247-2583 (TTY/TDD: 711) bilbili.
FRENCH	Pour des services d'assistance linguistique gratuits, appelez le (800) 247-2583 (TTY/TDD: 711).
GERMAN	Für kostenlose Sprachunterstützungsdienste rufen Sie (800) 247-2583 (TTY/TDD: 711) an.
ITALIAN	Per i servizi di assistenza linguistica gratuiti, chiamare il numero (800) 247-2583 (TTY/TDD: 711).
JAPANESE	無料の言語支援サービスについては, (800) 247-2583 (TTY/TDD: 711).
NEPALI	निःशुल्क भाषा-सहायता सेवाहरूको लागि, कल गर्नुहोस् , (800) 247-2583 (TTY/TDD: 711). Niḥśulka bhāṣā-sahāyatā sēvāharūkō lāgi, kala garnuhōs (800) 247-2583 (TTY/TDD: 711).
PORTUGUESE	Para serviços gratuitos de assistência linguística, ligue para (800) 247-2583 (TTY/TDD: 711).
RUSSIAN	Чтобы получить бесплатную языковую помощь, позвоните по телефону (800) 247-2583 (TTY/TDD: 711).
SERBO-CROATIAN (SERBIAN)	За бесплатне услуге језичке помоћи позовите (800) 247-2583 (TTY/TDD: 711). Za besplatne usluge jezičke pomoći pozovite (800) 247-2583 (TTY/TDD: 711).
SPANISH	Para servicios gratuitos de asistencia lingüística, llame al (800) 247-2583 (TTY/TDD: 711).
TAGALOG	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (800) 247-2583 (TTY/TDD: 711).
THAI	สำหรับบริการช่วยเหลือด้านภาษาฟรี โทร.(800) 247-2583 (TTY/TDD: 711). Sǎmṙab brikār ch̄wyĥelūx dān phās'a frī thor (800) 247-2583 (TTY/TDD: 711).
UKRAINIAN	Щоб отримати безкоштовні мовні послуги, телефонуйте (800) 247-2583 (TTY/TDD: 711). Shchob otrymaty bezkoshtovni movni posluhy, telefonuyte (800) 247-2583 (TTY/TDD: 711)
VIETNAMESE	Đối với các dịch vụ hỗ trợ ngôn ngữ miễn phí, hãy gọi (800) 247-2583 (TTY/TDD: 711).