

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

**Coverage Period:** 12/01/2022-11/30/2023  
**Coverage for:** Individual + Family | **Plan Type:** PPO

BlueCross BlueShield of Texas : **G650CHC Blue Choice Gold PPOS™ 801**

 **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.bcbstx.com/member/policy-forms/2022](http://www.bcbstx.com/member/policy-forms/2022) or by calling 1-800-521-2227. 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:
<b>What is the overall deductible?</b>	Network: \$3,000 Individual/\$9,000 Family Out-of-Network: \$6,000 Individual/\$18,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
<b>Are there services covered before you meet your deductible?</b>	Yes. In-Network Preventive Health Care Services and certain services with a copayment are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet deductibles for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	Network: \$3,000 Individual/\$9,000 Family Out-of-Network: Unlimited Individual/Unlimited Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
<b>What is not included in the out-of-pocket limit?</b>	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.bcbstx.com/go/bcpopo">www.bcbstx.com/go/bcpopo</a> or call 1-800-521-2227 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
<b>Do you need a referral to see a specialist?</b>	No.	You can see the specialist you choose without a referral.



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	Network Providers (You will pay the least)	What You Will Pay	Out-of-Network Providers (You will pay the most)	Limitations, Exceptions, & Other Important Information
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness  <u>Specialist</u> visit  <u>Preventive</u> care/screening/immunization	\$40/visit; <u>deductible</u> does not apply  \$80/visit; <u>deductible</u> does not apply  No Charge; <u>deductible</u> does not apply	20% <u>coinsurance</u>  20% <u>coinsurance</u>  20% <u>coinsurance</u>	Virtual Visits are available. See your benefit booklet* for details.  None  You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.	
<b>If you have a test</b>	Diagnostic test (X-ray, blood work)  Imaging (CT/PET scans, MRIs)	Lab: No Charge after <u>deductible</u> X-Rays: \$100/test plus <u>plan deductible</u>  \$250/test; <u>deductible</u> does not apply	20% <u>coinsurance</u>  20% <u>coinsurance</u>	Preauthorization may be required. See your benefit booklet* for details.  Preauthorization may be required. See your benefit booklet* for details.	

Common Medical Event	Services You May Need	What You Will Pay Network Providers (You will pay the least)	Out-of-Network Providers (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Preferred generic drugs  Non-preferred generic drugs  Preferred brand drugs  Non-preferred brand drugs  Preferred specialty drugs  Non-preferred specialty drugs	<p>No Charge after <u>deductible</u></p>	<p>Retail - No Charge after <u>deductible</u> plus 50% additional charge</p> <p>Retail - No Charge after <u>deductible</u> plus 50% additional charge</p> <p>Retail - No Charge after <u>deductible</u> plus 50% additional charge</p> <p>Retail - No Charge after <u>deductible</u> plus 50% additional charge</p> <p>No Charge after <u>deductible</u> plus 50% additional charge</p> <p>No Charge after <u>deductible</u> plus 50% additional charge</p>	<p>Limited to a 30-day supply at retail (or a 90-day supply at a <u>network</u> of select retail pharmacies). Up to a 90-day supply at mail order. <u>Speciﬁcally drugs</u> limited to a 30-day supply. Payment of the difference between the cost of a brand name drug and a generic may also be required if a generic drug is available. Additional Out-of-Network change will not apply to any deductible or out-of-pocket amounts. Certain drugs require approval before they will be covered.</p> <p>Cost-sharing for insulin included in the drug list will not exceed \$25 per prescription for a 30-day supply, regardless of the amount or type of insulin needed to ﬁll the prescription.</p>
				<p><u>Preauthorization</u> may be required. For Outpatient Infusion Therapy, see your benefit booklet* for details.</p>
				<p><u>Copayment</u> waived if admitted. Out-of-Network <u>cost share</u> is subject to <u>Network deductible</u>.</p>
	<b>If you need immediate medical attention</b>	<u>Emergency medical transportation</u>	No Charge after <u>deductible</u>	<p><u>Preauthorization</u> may be required for non-emergency transportation; see your benefit booklet* for details.</p>
	<u>Urgent care</u>	\$75/visit; <u>deductible</u> does not apply	20% <u>coinsurance</u>	None

\*For more information about limitations and exceptions, see the plan or policy document at [www.bcbstx.com/member/policy-forms/2022](http://www.bcbstx.com/member/policy-forms/2022).

Common Medical Event	Services You May Need	What You Will Pay Network Providers (You will pay the least)	Out-of-Network Providers (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have a hospital stay	<p>Facility fee (e.g., hospital room)</p> <p>Physician/surgeon fees</p>	<p>\$350/visit plus <u>plan deductible</u></p> <p>No Charge after <u>deductible</u></p>	<p>\$400/visit plus 20% coinsurance</p> <p>20% <u>coinsurance</u></p>	<p><u>Preauthorization</u> required. <u>Preauthorization</u> penalty: \$250 Out-of-Network. See your benefit booklet* for details.</p> <p><u>Preauthorization</u> required. See your benefit booklet* for details.</p>
If you need mental health, behavioral health, or substance abuse services	<p>Outpatient services</p> <p>Inpatient services</p>	<p>\$40/office visits; <u>deductible</u> does not apply; No Charge for other outpatient services</p> <p>\$350/visit plus <u>plan deductible</u></p>	<p>20% <u>coinsurance</u></p> <p>\$400/visit plus 20% coinsurance</p>	<p><u>Preauthorization</u> may be required; see your benefit booklet* for details.</p> <p><u>Preauthorization</u> required. <u>Preauthorization</u> penalty: \$250 Out-of-Network. See your benefit booklet* for details.</p>

\*For more information about limitations and exceptions, see the plan or policy document at [www.bcbstx.com/member/policy-forms/2022](http://www.bcbstx.com/member/policy-forms/2022).

Common Medical Event	Services You May Need	What You Will Pay Network Providers (You will pay the least)	Out-of-Network Providers (You will pay the most)	Limitations, Exceptions, & Other Important Information
<b>If you are pregnant</b>	Office visits	Primary Care: \$40/initial visit Specialist: \$80/initial visit; <u>deductible</u> does not apply	20% <u>coinsurance</u>	Copayment applies to first prenatal visit (per pregnancy). Cost sharing does not apply for preventive services. Depending on the type of services, <u>copayment</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No Charge after <u>deductible</u>	20% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$350/visit plus <u>plan deductible</u>	\$400/visit plus 20% <u>coinsurance</u>	
	Home health care	No Charge after <u>deductible</u>	20% <u>coinsurance</u>	60 visits/year. Preauthorization may be required.
	Rehabilitation services	No Charge after <u>deductible</u>	20% <u>coinsurance</u>	Separate 35 visit maximum per benefit period for <u>Habilitation</u> and <u>Rehabilitation</u> services, including chiropractic care. <u>Preauthorization</u> may be required; see your benefit booklet* for details.
	Habilitation services	No Charge after <u>deductible</u>	20% <u>coinsurance</u>	
	Skilled nursing care	No Charge after <u>deductible</u>	20% <u>coinsurance</u>	25 days/year. Preauthorization may be required.
<b>If you need recovering or have other special health needs</b>	Durable medical equipment	No Charge after <u>deductible</u>	20% <u>coinsurance</u>	Preauthorization may be required.
	Hospice services	No Charge after <u>deductible</u>	20% <u>coinsurance</u>	Preauthorization may be required.
	Children's eye exam	No Charge; <u>deductible</u> does not apply	Up to a \$30 reimbursement is available; <u>deductible</u> does not apply	One visit per year. Out-of-Network reimbursement will not exceed the retail cost. See your benefit booklet* (Pediatric Vision Care Benefits) for details.
	Children's glasses	No Charge; <u>deductible</u> does not apply	Reimbursement is available; <u>deductible</u> does not apply	One pair of glasses every 12 months. Reimbursement for frames, lenses, and lens options purchased Out-of-Network is available (not to exceed the retail cost). See your benefit booklet* (Pediatric Vision Care Benefits) for details.

\*For more information about limitations and exceptions, see the plan or policy document at [www.bcbstx.com/member/policy-forms/2022](http://www.bcbstx.com/member/policy-forms/2022).

Common Medical Event	Services You May Need	What You Will Pay Network Providers (You will pay the least)	Out-of-Network Providers (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Children's dental check-up	No Charge after <u>deductible</u>	No Charge after <u>deductible</u>	Oral exams are limited to two every benefit period. Benefits for periodic and comprehensive oral evaluations are limited to a combined maximum of two every 12 months. See your benefit booklet* (Pediatric Dental Benefits Rider) for details.

### 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.)

- Abortion (except for a pregnancy that, as certified by a physician, places the woman in danger of death or a serious risk of substantial impairment of a major bodily function unless an abortion is performed)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery (except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors, or diseases when medically necessary)
- Dental care (Adult)
- Infertility treatment (diagnosis and treatment covered; in vitro not covered)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (except for extended care)
- Routine eye care (Adult)
- Routine foot care (except in connection with diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency)
- Weight loss programs

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

- Chiropractic care (35 visits/year combined with habilitation and rehabilitation services)
- Hearing aids (limited to one hearing aid per ear every 36 months)

**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 Blue Cross and Blue Shield of Texas at 1-888-697-0683 or visit [www.bcbstx.com](http://www.bcbstx.com). For group health coverage subject to ERISA, contact the 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). For non-federal governmental group health plans, contact 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). Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law. 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: For group health coverage subject to ERISA: Blue Cross and Blue Shield of Texas at or visit [www.bcbstx.com](http://www.bcbstx.com), the 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), and the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or [www.tdi.texas.gov](http://www.tdi.texas.gov). For non-federal governmental group health plans and church plans that are group health plans, Blue Cross and Blue Shield of Texas at 1-800-521-2227 or [www.bcbstx.com](http://www.bcbstx.com) or contact the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or [www.tdi.texas.gov](http://www.tdi.texas.gov). Additionally, a consumer assistance program can help you file your appeal. Contact the Texas Department of Insurance's Consumer Health Assistance Program at 1-800-252-3439 or visit [www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/tx.html](http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/tx.html).

**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 1-800-521-2227.

Tagalog (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-800-521-2227.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-521-2227.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwilijo holne' 1-800-521-2227.

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)

<b>The plan's overall deductible</b>	\$3,000
<b>Specialist copayment</b>	\$80
<b>Hospital (facility) copayment</b>	\$350
<b>Other</b>	\$0

**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)

### Total Example Cost

**Total Example Cost** \$12,700

### In this example, Peg would pay:

Cost Sharing	What isn't covered
Deductibles	\$60
Copayments	\$0
Coinsurance	\$0
Limits or exclusions	\$20
<b>The total Peg would pay is</b>	<b>\$3,060</b>

### Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)

<b>The plan's overall deductible</b>	\$3,000
<b>Specialist copayment</b>	\$80
<b>Hospital (facility) copayment</b>	\$350
<b>Other</b>	\$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)

### Total Example Cost

**Total Example Cost** \$5,600

### In this example, Joe would pay:

Cost Sharing	What isn't covered
Deductibles	\$1,300
Copayments	\$800
Coinsurance	\$0
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,120</b>

### Mia's Simple Fracture (in-network emergency room visit and follow up care)

<b>The plan's overall deductible</b>	\$3,000
<b>Specialist copayment</b>	\$80
<b>Hospital (facility) copayment</b>	\$350
<b>Other</b>	\$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)

### Total Example Cost

**Total Example Cost** \$2,800

### In this example, Mia would pay:

Cost Sharing	What isn't covered
Deductibles	\$2,300
Copayments	\$400
Coinsurance	\$0
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,700</b>

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



**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  
Email: CivilRightsCoordinator@hcsc.net

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>

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 تساعدك في الحصول على المساعدة والمعلومات الضرورية بذلك من دون أي تكاليف، يمكنك الحصول على المساعدة والمعلومات الضرورية بذلك من دون أي تكاليف. للتحدث مع مترجم فوري، اتصل بلغة الرم ٨٥٥-٧١٠-٦٩٨٤.
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 કરો રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ બી. એમ્. કાયાંક્રમ બાબતે પ્રશ્ન હોય, તો તમને [લેના ખ ચેર], તમારી ભાષામાં મદદ અને માહિતી મેળવવાની હક્ક છે. ડુસિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કોલ કરો.
हिन्दी Hindi	चिद आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपके अपनी भाषा में:शुल्क सहायता और जानकारी प्राप्त करन का अधिकार है। किसी अनावादक स बात करन क लिए 855-710-6984 पर काल करें।
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenerne aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 구하려 또는 구하는 사람의 질문이 있다면, 거하는 무료로 그러한 도움과 정보를 구하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago la' da biká anánilwo'ígíí, na 'ídilkidgo, ts' idá bee ná ahóóti'i: t'áá niik' e niká a' doolwol dóó bina 'ídilkidgií bee nil h odoonih. Ata' dahalne 'ígíí bichí'i' hodilínih kwe' é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارد که زبان خود، به طور رایگان کمک و اطلاعات دریافت نماید. جو هست گفتنگو با یک مترجم شهافی، با شماره 855-710-6984 تماسا حصل نماید.
Polski Polish	Jesli Ty lub osoba, której pomagasz, maćie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoni 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 tinitutulungan ay may mga tanong, may karapatan kang makauha 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 اپسے فرد کو جس کیا آپ جد کروئے ہیں کوئی معلوم اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لئے، آپ کو پہنچنے میں مختتم اور معلوم اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لئے، آپ کو پہنچنے میں مختتم اور معلوم اور معلومات حاصل کرنے کا حق ہے۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thi 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.