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 our website at MolinaMarketplace.com or call 1-888-295-7651. For 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 or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	$500 / individual or $1,000 / family Combined Medical and Rx	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.
Are there services covered before you meet your deductible?	Yes. All covered services except ER room, Inpatient services, and Non-preferred brand prescription drugs. Testing, vaccination, and delivery of healthcare services related to COVID-19	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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$2,400 / individual or $4,800 /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.
What is not included in the out-of-pocket limit?	Premiums, balance-billing 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.
Will you pay less if you use a network provider?	Yes. See Molina Marketplace Network at MolinaMarketplace.com/NMFindCare or call 1-888-295-7651 for a list of network providers.	This plan uses a network provider. 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.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

Please Note: There is no charge for testing and delivery of healthcare services related to COVID-19.

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: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$7 copay /visit	Not covered	Other practitioner office visit is at the same cost share as primary care.
	Specialist visit	$20 copay /visit	Not covered	Preauthorization may be required or services may not be covered.
	Preventive care/screening/ immunization	No charge	Not covered	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. Including artery calcification testing for heart disease. Testing, vaccination and delivery of healthcare services related to COVID-19 are at No Charge.
If you have a test	Diagnostic test (x-ray, blood work)	$20 copay /test for blood work; $20 copay /test for x-rays	Not covered	Testing, vaccination and delivery of healthcare services related to COVID-19 are at No Charge.
	Imaging (CT/PET scans, MRIs)	$20 copay /test	Not covered	Preauthorization may be required or services may not be covered. For gynecological or obstetrical ultrasounds, preauthorization is not required.
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at http://www.molinamarketplace.com/NMFormulary2024.com**	Generic drugs	$5 copay (retail)	Not covered	Preauthorization may be required or services may not be covered. Mail-order Prescription Drugs are available at a 90-day supply and is offered at two-and-a-half times the 30-day retail prescription Cost Sharing. Depending on Tier level this will be either a Copayment or a Coinsurance. Insulin or a medically necessary alternative will not exceed a total of twenty-five dollars($25.00) per thirty-day supply. Behavioral Health, or Substance Abuse drugs subject to Senate Bill 317 are at No Charge. Preventive Care and Contraceptive Drugs are at No Charge. Cost-sharing accumulation for any third-party payment such as a drug manufacturers coupon is not allowed. Testing, vaccination, and delivery of healthcare services related to COVID-19 are at No Charge.
	Preferred brand drugs	$10 copay (retail)	Not covered	
	Non-preferred brand drugs	$100 copay after deductible (retail)	Not covered	
	Specialty drugs	Preferred - $50 copay (retail)/ Non-Preferred - $125 copay (retail)	Not covered	

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$60 copay	Not covered	Preauthorization may be required or services may not be covered.
	Physician/surgeon fees	$60 copay	Not covered	Preauthorization may be required or services may not be covered. Laser corrective eye surgery is not covered.
If you need immediate medical attention	Emergency room care	$75 copay after deductible / visit	$75 copay after deductible / visit	Emergency room care copay does not apply, if admitted to the hospital. Amounts you pay, such as deductible, copayments or coinsurance, for emergency services whether provided by contracted or non-contracted providers are applied to your out-of-pocket limit. Balance billing is not allowed for out-of-network care.
	Emergency medical transportation	$20 copay	$20 copay	
	Urgent care	$20 copay	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$75 copay after deductible	Not covered	Preauthorization is required or services may not be covered.
	Physician/surgeon fees	$75 copay after deductible	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge /office visit and Outpatient Intensive Psychiatric Treatment Programs No Charge	Not covered	Preauthorization is required for inpatient care or services may not be covered.
	Inpatient services	No Charge	Not covered	
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply to routine prenatal care and first post-natal visit and certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described. Preauthorization is not required for maternity ultrasounds.
	Childbirth/delivery professional services	$75 copay after deductible/visit	Not covered	
	Childbirth/delivery facility services	$75 copay after deductible	Not covered	

		What You Will Pay:		
Common Medical Event	**Services You May Need**	**Network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	**Limitations, Exceptions, & Other Important Information**
If you need help recovering or have other special needs	Home health care	$7 copay/per day	Not covered	100 visits/year. Services must be provided by an in network Home health agency.
	Rehabilitation services	$7 copay/visit	Not covered	Preauthorization is required for inpatient care or services may not be covered. Visit limit does not apply.
	Habilitation services	$7 copay/visit	Not covered	Preauthorization is required for inpatient care or services may not be covered. Visit limit does not apply.
	Skilled nursing care	$20 copay	Not covered	60 days/calendar year. Preauthorization is required or services may not be covered.
	Durable medical equipment	$7 copay	Not covered	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	$20 copay/ per day	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Coverage limited to one exam including refraction/year.
	Children's glasses	No charge	Not covered	Coverage limited to one pair of glasses/year.
	Children's dental checkups	Not covered	Not covered	Not Applicable. Coverage can be purchased as a standalone product; it is not covered by this policy.

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 in cases of rape, incest, or when the life of the mother is endangered) • Cosmetic Surgery • Dental Care (Adult, routine dental)	• Long-Term Care • Non-emergency care when traveling outside the U.S • Private Duty Nursing	• Routine eye care (Adult) • Routine Foot Care (Unless you are diabetic) • Weight Loss Programs (unless for dietary evaluation and counseling for medical management of morbid obesity and obesity are covered)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (up to 20 visits per year, unless for rehabilitative or habilitative purposes) • Bariatric Surgery	• Chiropractic Care (up to 20 visits per year, unless for rehabilitative or habilitative purposes) • Hearing Aids (one hearing aid per ear every 36 months)	• Infertility (limited to diagnosis and medically indicated treatments for physical conditions causing infertility)

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: New Mexico Office of Superintendent of Insurance 1 (833) 415-0566 or www.osi.state.nm.us, and beWellnm 1 (833) 862-3925 or www.beWellnm.com. 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 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: Molina Healthcare of New Mexico at 1 (888) 295-7651 or the Office of Superintendent of Insurance, Managed Health Care Bureau at 1-833-415-0566) or mhcb.grievance@state.nm.us.

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) 295-7651.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1 (888) 295-7651.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1 (888) 295-7651.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1 (888) 295-7651.

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

* For more information about limitations and exceptions, see the plan or policy document at www.MolinaMarketplace.com

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 $500
  Specialist Copayment $20
- Hospital (facility)
  copay after ded $75
- Other copay after ded $75

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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,100**

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

- The plan's overall deductible $500
  Specialist Copayment $20
- Hospital (facility)
  copay after ded $75
- Other copay after ded $75

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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,100**

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

- The plan's overall deductible $500
  Specialist Copayment $20
- Hospital (facility)
  copay after ded $75
- Other copay after ded $75

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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$400
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$700**

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

Non-Discrimination Notification
Molina Healthcare

Your Extended Family.

Molina Healthcare (Molina) complies with all Federal civil rights laws that relate to healthcare services. Molina offers healthcare services to all members and does not discriminate based on race, color, national origin, ancestry, age, disability, or sex.

Molina also complies with applicable state laws and does not discriminate on the basis of creed, gender, gender expression or identity, sexual orientation, marital status, religion, honorably discharged veteran or military status, or the use of a trained dog guide or service animal by a person with a disability.

To help you talk with us, Molina provides services free of charge, in a timely manner:

- Aids and services to people with disabilities
  - Skilled sign language interpreters
  - Written material in other formats (large print, audio, accessible electronic formats, Braille)
- Language services to people who speak another language or have limited English skills
  - Skilled interpreters
  - Written material translated in your language

If you need these services, contact Molina Member Services. The Molina Member Services number is on the back of your Member Identification card. (TTY: 711).

If you think that Molina failed to provide these services or discriminated based on your race, color, national origin, age, disability, or sex, you can file a complaint. You can file a complaint in person, by mail, fax, or email. If you need help writing your complaint, we will help you. Call our Civil Rights Coordinator at (866) 606-3889, or TTY: 711.

Mail your complaint to: Civil Rights Coordinator, 200 Oceangate, Long Beach, CA 90802.

You can also email your complaint to civil.rights@molinahealthcare.com.

You can also file your complaint with Molina Healthcare AlertLine, twenty four hours a day, seven days a week at: https://molinahealthcare.alertline.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Complaint forms are available at https://www.hhs.gov/ocr/complaints/index.html You can mail it to:

U.S. Department of Health and Human Services,
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

You can also send it to a website through the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

If you need help, call (800) 368-1019; TTY (800) 537-7697.

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ATTENTION: Aids and services for people with disabilities, like documents in braille and large print, arealso available. If you need help in your language call Member Services located on back of your ID card.(TTY: 711). These services are free of charge.

ATENCIÓN: Si necesita ayuda en su idioma llame a Servicios para Miembros. El número está en el reverso de su tarjeta de identificación de miembro. (TTY: 711). También hay disponibles ayudas y servicios para personas con discapacidades, como documentos en braille y letra grande. Estos serviciosson gratuitos. (Spanish)

. تنبه: إذا كنت بحاجة الى مساعدة في لغتك ، فاتصل، بخدمات الأعضاء. الرقم موجود على ظهر بطاقة هوية العضو الخاصة بك |
(Arabic) .(الهاتف النصي: 711). تتوفر أيضا مساعدات وخدمات للأشخاص ذوي الإعاقة، مثل المستندات بطريقة برايل والطباعة الكبيرة. هذه الخدمات مجانية

ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե ձեր լեզվով օգնության կարիք ունեք, զանգահարեք Member Services: Համարը գտնվում է Ձեր Member ID քարտիետևի մասում: (TTY: 711):
Առկա են նաեւ հաշմանդամություն ունեցող անձանց համար նախատեսված օժանդակ միջոցներ եւ ծառայություններ, ինչպես բրեյլի եւ մեծ տպաքանակի փաստաթղթեր: Այս ծառայությունները անվճար են: (Armenian)

ការយកចំនុចទុកដាក់៖ជំនួយនឹងសេវាកម្មសម្រាប់ជនពិការរួចជាឯកសារក្នុងអក្សរទ្រនាប់នឹងព្រីនធំក៏មានផងដែរ.
ប្រសិនបើអ្នកត្រូវការជំនួយក្នុងការហៅភាសារបស់អ្នកថាសមាជិកសេវាកម្មដែលមានទីតាំងនៅខាងក្រោយអនុសញ្ញាណប័ណ្ណរបស់អ្នក, (TTY: ៧១១), សេវាកម្មទាំងនេះដោយមិនគិតថ្លៃ, (Cambodian)

注意:如果您需要语言方面的帮助, 请致电会员服务部。该号码位于您的会员 ID 卡背面。(TTY: 711)。
还为残疾人提供辅助工具和服务, 如盲文和大字体文件。这些服务是免费的。(Chinese Simplified)

توجه: کمک ها و خدمات برای افراد معلول, مانند اسناد بریل
. و چاپ بزرگ نیز در دسترس هستند. در صورت نیاز به کمک در زبان خود با خدمات عضو واقع در پشت کارت شناسایی خود تماس بگیرید
(Farsi) .این خدمات رایگان هستند . (TTY: 711)

ध्यान दें: यदि आपको अपनी भाषा में सहायता की आवश्यकता है, तो सदस्य सेवाओं को कॉल करें। नंबर आपके सदस्य आईडी कार्ड के पीछे है। (TTY: 711)। विकलांग लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में दस्तावेज, भी उपलब्ध हैं। ये सेवाएं नि: शुल्क हैं। (Hindi)

XIM: Yog koj xav tau kev pab los ntawm koj cov kev pab. Tus naj npawb nyob sab nraum qab ntawm koj tus ID card. (TTY: 711).
Aids thiab kev pab rau cov neeg uas muaj mob xiam oob qhab, xws li cov ntaub ntawv nyob rau hauv braille thiab loj print, kuj muaj. Cov kev pab no yog pab dawb xwb. (Hmong)

ACHTUNG: Wenn Sie Hilfe in Ihrer Sprache benötigen, rufen Sie den Mitgliederservice an. Die Nummer finden Sie auf der Rückseite Ihres Mitgliedsausweises. (TTY: 711).
Hilfsmittel und Dienstleistungen für Menschen mit Behinderungen, wie Dokumente in Blindenschrift und Großdruck, sind ebenfalls verfügbar. Diese Dienstleistungen sind kostenlos. (German)

Languages: English, Spanish, Arabic, Armenian, Cambodian, Chinese, Farsi, Hindi, Hmong, German, Japanese, Korean, Loatian, Mien, Navajo, Punjabi, Russian, Tagalog, Thai, Ukrainian, Vietnamese

注意:あなたの言語で助けが必要な場合は、メンバーサービスに電話してください。番号は会員証の裏面に記載されています。(TTY: 711)。
点字や大活字の書類など、障害者のための援助やサービスも利用できます。これらのサービスは無料です。(Japanese)

주의: 귀하의 언어로 도움이 필요하면 회원 서비스에 전화하십시오. 이 번호는 가입자 ID 카드 뒷면에 있습니다. (TTY: 711) 입니다.
점자 및 큰 활자로 된 문서와 같은 장애인을 위한 보조 및 서비스도 제공됩니다. 이러한 서비스는 무료입니다. (Korean)

ຂໍ້ຄວນລະວັງ: Aids ແລະການບໍລິການສຳລັບຄົນພິການ, ເຊັ່ນດຽວກັບເອກະສານໃນ braille ແລະການພິມຂະຫນາດໃຫຍ່, ຍັງມີ. ຖ້າ ທ່ານ ຕ້ອງ ການ ຄວາມ ຊ່ວຍ ເຫຼືອ ໃນ ພາ ສາ ຂອງ ທ່ານ call Member Services ທີ່ ຕັ້ງ ຢູ່ ທາງ ຫລັງ ຂອງ ບັດ ID ຂອງ ທ່ານ. (TTY: 711). ການບໍລິການເຫຼົ່ານີ້ແມ່ນບໍ່ເສຍຄ່າ. (Loatian)

attention: aids caux services bun mienh caux disabilities oix documents yie braille caux large print naaic yaac available da'faanh meih oix zuqc tengx yie meih nyei language heuc member services located zieqc back of meih nyei yie cie (tty: 711) these services naaic free of charge. (Mien)

BAA'ÁKOHWIINIDZIN: Diné t'áá haashíį yit'éego bich'į' aníhoot'i'ígíí bá áka'anídaalwo'í dóó bee áka'anída'awo'í, díí naaltsoos bee éédahoziní bik'ih nizhdilniihgo wólta'í dóó nitsaago bee bik'eda'ashchínígíí ałdó' hóló. T'áá nizaadjí bee shiká'adoowoł nínízingo ninaaltsoos ID nitł'isí bine'dęę' biká'ígíí bee Bił Hada'dít'éhí Bika'anída'wo' bich'į' hodíilnih. (TTY: 711). Díí bee áka'anída'awo'í doo bąąh ilíní da. (Navajo)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਮੈਂਬਰ ਸੇਵਾਵਾਂ ਨੂੰ ਕਾਲ ਕਰੋ। ਨੰਬਰ ਤੁਹਾਡੇ ਮੈਂਬਰ ID ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਹੈ। (TTY: 711).
ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ। ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ। (Punjabi)

ВНИМАНИЕ: Если вам нужна помощь на вашем языке, позвоните в службу поддержки. Номер указан на обратной стороне вашей идентификационной карты. (Телетайп: 711). Также доступны вспомогательные средства и услуги для людей с ограниченными возможностями, такие как документы, напечатанные шрифтом Брайля и крупным шрифтом. Эти услуги бесплатны. (Russian)

ATTENTION: Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan, tulad ng mga dokumento sa braille at malaking print.
Kung kailangan mo ng tulong sa iyong wika tumawag sa Member Services na matatagpuan sa likod ng iyong ID card. (TTY: 711).
Ang mga serbisyong ito ay libre. (Tagalog)

ความสนใจ: หากคุณต้องการความช่วยเหลือในภาษาของคุณโทรติดต่อฝ่ายบริการสมาชิก หมายเลขจะอยู่ด้านหลังบัตรประจำตัวสมาชิกของคุณ (TTY: 711)
นอกจากนี้ยังมีบริการช่วยเหลือสำหรับคนพิการ เช่น เอกสารอักษรเบรลล์และสิ่งพิมพ์ขนาดใหญ่ บริการเหล่านี้ไม่มีค่าใช้จ่าย (Thai)

УВАГА: Якщо вам потрібна допомога вашою мовою, зателефонуйте до служби підтримки. Номер вказано на зворотному боці посвідчення учасника. (ЛТАЙП: 711). Також доступні допоміжні засоби та послуги для людей з обмеженими можливостями, такі як документи шрифтом Брайля та великим шрифтом. Ці послуги безкоштовні. (Ukrainian)

Languages: English, Spanish, Arabic, Armenian, Cambodian, Chinese, Farsi, Hindi, Hmong, German, Japanese, Korean, Loatian, Mien, Navajo, Punjabi, Russian, Tagalog, Thai, Ukrainian, Vietnamese

CHÚ Ý: Nếu bạn cần trợ giúp bằng ngôn ngữ của mình, hãy gọi cho Dịch vụ Hội viên. Số này nằm ở mặt sau thẻ ID Hội viên của bạn. (TTY: 711).
Hỗ trợ và dịch vụ cho người khuyết tật, như tài liệu bằng chữ nổi và chữ in lớn, cũng có sẵn. Các dịch vụ này là miễn phí. (Vietnamese)

Languages: English, Spanish, Arabic, Armenian, Cambodian, Chinese, Farsi, Hindi, Hmong, German, Japanese, Korean, Loatian, Mien, Navajo, Punjabi, Russian, Tagalog, Thai, Ukrainian, Vietnamese