

Blue Cross® and Blue Shield® of Minnesota and Blue Plus® are nonprofit

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services RAMSEY COUNTY

Coverage Period: Beginning on or after 01/01/2025 Coverage for: Individual/Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 <u>bluecrossmn.com</u> or call 1-844-348-0582. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at <u>https://www.healthcare.gov/sbc-glossary</u> or call 1-866-873-5943 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$1,650 individual / \$3,300 family medical and drug <u>in-network</u> \$4,850 individual / \$9,700 family medical and drug <u>out-of-network</u>	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. This <u>plan</u> has a non-embedded <u>deductible</u> . If you have other family members on this <u>plan</u> , the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	Yes. Well child care, prenatal care and <u>in-network</u> <u>preventive care</u> services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <u>https://www.healthcare.gov/coverage/preventive-care-benefits</u> .
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet deductibles for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this plan?	\$6,000 individual / \$12,000 family medical and drug <u>in-network</u> \$12,000 individual / \$24,000 family medical and drug <u>out-of-network</u>	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. This <u>plan</u> has a non-embedded <u>out-of-pocket limit</u> . If you have other family members on this <u>plan</u> , the overall family <u>out-of-pocket limit</u> must be met.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billing charges (unless balanced billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> <u>limit</u> .

Will you pay less if you use an <u>in-network</u> <u>provider</u> ?	Yes. Your <u>network</u> is. Aware®. See <u>bluecrossmn.com/find-a-doctor/#/home</u> or call 1- 866-873-5943 for a list of <u>in-network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>in-network</u> <u>provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

Common Medical Event	Services You May Need	What yo In-Network Provider (You will pay the least)	u Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	None
	Specialist visit	20% coinsurance	40% coinsurance	None
If you visit a health care provider's office or clinic	Preventive care/screening/ immunization	No charge	Well child: No charge Adult: 40% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	May require prior authorization
If you have a test	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	May require prior authorization.
If you need drugs to treat your illness or condition.	Preferred generic drugs	\$10.00 <u>copay</u> /prescription (retail) \$30.00 <u>copay</u> /prescription (mail service) \$30.00 <u>copay</u> /prescription (90dayRx retail)	Not covered	Covers up to a 31-day supply (retail prescription); 90-day supply (mail service prescription and 90dayRx retail prescription). You will pay no more than \$25 for a one-month
More information about <u>prescription</u> <u>drug coverage</u> is available at <u>bluecrossmn.com</u>	Preferred brand drugs	<pre>\$25.00 copay/prescription (retail) \$75.00 copay/prescription (mail service) \$75.00 copay/prescription (90dayRx retail)</pre>	Not covered	supply for each prescription for eligible drugs to treat certain chronic diseases. You may need to meet your <u>deductible</u> first. The value of drug coupons you use may count towards

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

		What you Will Pay		Limitations Europtions 9
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Non-preferred generic drugs	\$15.00 <u>copay</u> /prescription (retail) \$45.00 <u>copay</u> /prescription (mail service) \$45.00 <u>copay</u> /prescription (90dayRx retail)	Not covered	cost sharing or out-of-pocket limits. Drugs and drug tiers on the formulary may change with notice. May require prior authorization.
	Non-preferred brand drugs	\$35.00 <u>copay</u> /prescription (retail) \$105.00 <u>copay</u> /prescription (mail service) \$105.00 <u>copay</u> /prescription (90dayRx retail)	Not covered	
	<u>Specialty drugs</u>	20% <u>coinsurance</u> , up to a maximum of \$200	Not covered	Covers up to a 31-day supply (participating <u>specialty drug</u> network supplier required). You will pay no more than \$25 for a one-month supply for each prescription for eligible drugs to treat certain chronic diseases. You may need to meet your <u>deductible</u> first. The value of drug coupons you use may count towards <u>cost sharing or</u> <u>out-of-pocket limits</u> . Drugs and drug tiers on the formulary may change with notice. May require prior authorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	May require prior authorization.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	May require prior authorization.
	Emergency room care	20% <u>coinsurance</u>	20% coinsurance	Out-of-network services apply
If you need immediate medical attention	Emergency medical transportation	20% <u>coinsurance</u>	20% coinsurance	to the <u>in-network</u> <u>deductible</u> and <u>out-of-pocket limit</u> .
	Urgent care	20% coinsurance	40% coinsurance	None

		What yo	Limitations Exceptions 0	
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fee	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance	Outpatient services	20% coinsurance	40% coinsurance	Services for marriage/couples counseling are not covered. May require prior authorization.
use services	Inpatient services including adult mental health treatment	20% <u>coinsurance</u>	40% coinsurance	Services for marriage/couples counseling are not covered. May require prior authorization.
	Office visits	Prenatal care: No charge Postnatal care: 20% <u>coinsurance</u>	Prenatal care: No charge Postnatal care: 40% <u>coinsurance</u>	<u>Cost-sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, other
If you are pregnant	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	<u>cost-sharing</u> may apply. Maternity care may include
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	tests and services described elsewhere in the SBC (e.g., ultrasound).
If you need help recovering or have other special health needs	Home health care	20% <u>coinsurance</u>	40% coinsurance	Combined 120 visits per person per benefit period. May require prior authorization.
	Rehabilitation services	20% <u>coinsurance</u> for occupational therapy, physical therapy, and speech therapy	40% <u>coinsurance</u> for occupational therapy, physical therapy, and speech therapy	Occupational, physical, and speech therapy are limited to a combined limit of 15 visits per
	Habilitation services	20% <u>coinsurance</u> for occupational therapy, physical therapy, and speech therapy	40% <u>coinsurance</u> for occupational therapy, physical therapy, and speech therapy	benefit period if you use an <u>out-of-network provider</u> . May require prior authorization.
	Skilled nursing care	20% coinsurance	40% coinsurance	Combined 120 days per person per benefit period. May require prior authorization.

		What yo	ou Will Pay	Limitationa Evagationa 9
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	<u>Durable medical</u> equipment	20% <u>coinsurance</u>	40% <u>coinsurance</u>	You will pay no more than \$50 per month for all eligible medical supplies to treat certain chronic diseases. You may need to meet your <u>deductible</u> first. May require prior authorization.
	Hospice service	20% coinsurance	40% coinsurance	None
If your child needs dental or eye	Children's eye exam	No charge	Age 0 through 5: No charge Age 6 through 18: 40% <u>coinsurance</u>	None
care	Children's glasses	Not covered	Not covered	No coverage for these services
	Children's dental check- up	Not covered	Not covered	No coverage for these services

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Co	ver (Check your policy or <u>plan</u> document for more inform	ation and a list of any other <u>excluded services</u> .)
 Acupuncture Cosmetic surgery Dental care (Adult) (and children) 	 Drugs not on the covered drug list unless an exception is obtained Long-term care Non-emergency care when traveling outside the U.S. 	 Private duty nursing Routine foot care Weight loss programs
Other Covered Services (Limitations may a	pply to these services. This isn't a complete list. Please s	ee your <u>plan</u> document.)
 Acupuncture Bariatric surgery Chiropractic care 	Infertility treatmentHearing aids	• Routine eye care (Adult)

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: Minnesota Department of Commerce at 1-800-657-3602; the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323, extension 61565 or www.cciio.cms.gov. For more information on your rights to continue coverage, contact Blue Cross at 1-866-873-5943. 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. For more information about the https://www.mnsure.com or call 1-855-366-7873.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also

provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: Blue Cross at 1-866-873-5943; the Minnesota Department of Commerce at 1-800-657-3602; the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <u>www.dol.gov/ebsa/healthreform</u>. If you are covered under a <u>plan</u> offered by the State Health Plan, a city, county, school district, or Service Cooperative, or church plan you may contact the Department of Health and Human Services Health Insurance team at 1-888-393-2789.

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 1-855-903-2583.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-537-7720.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-855-315-4017.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-902-2583.

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

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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, copayment 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 Ba (9 months of in-network prenata hospital delivery)		Managing Joe's type 2 Di (a year of routine in-network care controlled condition)	
 The <u>plan's</u> overall <u>deductible</u> <u>Specialist coinsurance</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$1,650 20% 20% 20%	 The <u>plan's</u> overall <u>deductible</u> <u>Specialist coinsurance</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$1
This EXAMPLE event includes se Specialist office visits (prenatal care	e)	This EXAMPLE event includes server Primary care physician office visits (in	
Childbirth/delivery facility services <u>Diagnostic tests</u> (<i>ultrasounds and b</i>		disease education) <u>Diagnostic tests</u> (blood work) <u>Prescription drugs</u> <u>Durable medical equipment</u> (glucose	meter)
Childbirth/delivery facility services <u>Diagnostic tests</u> (<i>ultrasounds and b</i> <u>Specialist</u> visit (anesthesia)		Diagnostic tests (blood work) Prescription drugs	meter) \$5
Childbirth/delivery facility services <u>Diagnostic tests</u> (<i>ultrasounds and bi</i> <u>Specialist</u> visit (<i>anesthesia</i>) Total Example Cost	lood work)	Diagnostic tests (blood work) Prescription drugs Durable medical equipment (glucose Total Example Cost	,
Childbirth/delivery facility services <u>Diagnostic tests</u> (<i>ultrasounds and bi</i> <u>Specialist</u> visit (<i>anesthesia</i>) Total Example Cost	lood work)	<u>Diagnostic tests</u> (blood work) <u>Prescription drugs</u> <u>Durable medical equipment</u> (glucose	,
Childbirth/delivery facility services <u>Diagnostic tests</u> (ultrasounds and bi <u>Specialist</u> visit (anesthesia) Total Example Cost In this example, Peg would pay: Cost Sharing	lood work)	Diagnostic tests(blood work)Prescription drugsDurable medical equipment(glucoseTotal Example CostIn this example, Joe would pay:	,
Childbirth/delivery facility services <u>Diagnostic tests</u> (<i>ultrasounds and bi</i> <u>Specialist</u> visit (<i>anesthesia</i>) Total Example Cost In this example, Peg would pay: <u>Cost Sharing</u> <u>Deductibles</u>	lood work) \$12,700	Diagnostic tests (blood work) Prescription drugs Durable medical equipment (glucose Total Example Cost In this example, Joe would pay: Cost Sharing	\$5
Childbirth/delivery professional serv Childbirth/delivery facility services <u>Diagnostic tests</u> (<i>ultrasounds and bi</i> <u>Specialist</u> visit (<i>anesthesia</i>) Total Example Cost In this example, Peg would pay: <u>Cost Sharing</u> <u>Deductibles</u> <u>Copayments</u> <u>Coinsurance</u>	lood work) \$12,700 \$1,650	Diagnostic tests (blood work) Prescription drugs Durable medical equipment (glucose Total Example Cost In this example, Joe would pay: Cost Sharing Deductibles	\$5
Childbirth/delivery facility services <u>Diagnostic tests</u> (ultrasounds and bi <u>Specialist</u> visit (anesthesia) Total Example Cost In this example, Peg would pay: <u>Cost Sharing</u> <u>Deductibles</u> <u>Copayments</u>	lood work) \$12,700 \$1,650 \$10 \$1,700	Diagnostic tests (blood work) Prescription drugs Durable medical equipment (glucose Total Example Cost In this example, Joe would pay: Cost Sharing Deductibles Copayments	\$5
Childbirth/delivery facility services <u>Diagnostic tests</u> (ultrasounds and bi <u>Specialist</u> visit (anesthesia) Total Example Cost In this example, Peg would pay: <u>Cost Sharing</u> <u>Deductibles</u> <u>Copayments</u> <u>Coinsurance</u>	lood work) \$12,700 \$1,650 \$10 \$1,700	Diagnostic tests (blood work) Prescription drugs Durable medical equipment (glucose Total Example Cost In this example, Joe would pay: Cost Sharing Deductibles Copayments Coinsurance	\$5

(a year of routine in-network care of controlled condition)	of a well-
IThe <u>plan's</u> overall <u>deductible</u>	\$1,650
Specialist coinsurance	20%
Hospital (facility) <u>coinsurance</u>	20%
Other coinsurance	20%
his EXAMPLE event includes servi	
rimary care physician office visits (inc	auding
isease education)	
iagnostic tests (blood work)	

Total Example Cost	\$5,600
In this example, Joe would pay:	
Cost Sharing	
Deductibles	\$1,650
<u>Copayments</u>	\$70
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$20
The total loe would pay is	\$1 840

Mia's Simple Fracture

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

■The <u>plan's</u> overall <u>deductible</u>	\$1,650
Specialist coinsurance	20%
Hospital (facility) <u>coinsurance</u>	20%
■Other <u>coinsurance</u>	20%

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	\$1,650
Copayments	\$10
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,860

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



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At Blue Cross and Blue Shield of Minnesota, we treat everyone fairly. We don't exclude you, or treat you less favorably, because of your race, skin color, national origin, age, disability status, or sex (including sexual orientation; sex characteristics including intersex traits; pregnancy or related conditions; gender identity; and sex stereotypes). We follow federal civil rights laws and don't discriminate against anyone based on these traits.

If you communicate best in a language other than English, you can request free language assistance services.

If you have a vision, hearing, or speech impairment, we can communicate in a way that works best for you. This may include using sign language interpreters, providing documents in large print or Braille, audio recordings, or other aids at no charge.

Need these services? Call 1-855-903-2583, TTY 711 or call the number on the back of your member identification card.

Discrimination is against the law.

If we failed to provide services or discriminated in another way based on your race, skin color, national origin, age, disability status, or sex, (including sexual orientation; sex characteristics including intersex traits; pregnancy or related conditions; gender identity; and sex stereotypes), you can file a complaint by contacting our Nondiscrimination Civil Rights Coordinator:

Email:Civil.Rights.Coord@bluecrossmn.comTelephone:1-800-509-5312Mail:Blue Cross and Blue Shield of
Minnesota ATTN: Civil Rights
Coordinator P3-2
PO Box 64560, Eagan, MN 55164-0560

Nondiscrimination complaint forms are available on our website at <u>bluecrossmn.com/NDL</u>, or from the Nondiscrimination Civil Rights Coordinator. You can also

file a civil rights complaint with the U.S. Department of Health and Human Services

- electronically through the Office for Civil Rights complaint portal: ocrportal.hhs.gov/ocr/portal/lobby.jsf
- by mail at: U.S. Department of Health and Human Services,
 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201
- or by phone at: 1-800-368-1019, 1-800-537-7697 (TDD)

Civil rights complaint forms are available at hhs.gov/ocr/office/file/index.html.

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ENGLISH ATTENTION: If you speak a language other than English, language services are available free of charge. If you have a vision, hearing, or speech impairment, we can communicate in a way that works best for you. This may include using sign language interpreters, providing documents in large print or Braille, audio recordings, or other aids at no charge. Call 1-855-903-2583 (TTY 711).	廣東話 (Cantonese – Traditional Chinese) 請注意:如果您說 廣東話 您可要求免費語言協助服務。 如果您有視力、聽力或言語障礙,我們會以最適合您的方式與您溝通 這可能包括使用手語傳譯員、免費提供大字體或點字文件、 錄音或其他輔助工具。請致電 1-855-903-2583 聽障熱線 (TTY 711)。
ESPAÑOL (Spanish) ATENCIÓN: Si habla Español, puede solicitar servicios gratuitos de asistencia lingüística. Si tiene una deficiencia visual, auditiva o del habla, podemos comunicarnos de la manera que le resulte mejor a usted. Esto puede incluir el uso de intérpretes de lengua de señas, el suministro de documentos en letra grande o braille, grabaciones de audio u otras ayudas sin cargo. Llame al 1-855-903-2583 (TTY 711).	العربية (Arabic) تتبيه: إذا كنت تتحدث العربية، يمكنك طلب خدمات المساعدة اللغوية المجانية. إذا كنت تعاني من إعاقة بصرية أو سمعية أو نطقية، يمكننا التواصل معك بالطريقة التي تناسبك. وقد يشمل ذلك استخدام مترجمين للغة الإشارة، أو توفير المستندات بحروف كبيرة أو بطريقة برايل، أو تسجيلات صوتية، أو غيرها من الوسائل المساعدة من دون مقابل. اتصل على الرقم 2583-903-1855-1981)الهاتف النصبي 711(.
አማርኛ (Amharic) ትኩረት ይሰጥ፦ አማርኛ ቋንቋ የሚናንሩ ከሆነ፣ ነጻ የቋንቋ እንዛ አንልግሎቶችን መጠየቅ ይችላሉ። የማየት፣ የመስማት ወይም የመናንር ችግር ካለብዎት ለእርስዎ በተሻለ በሚሠራው መንንድ መግባባት እንችላለን። ይህ ደግሞ የምልክት ቋንቋ አስተርዳሚዎችን መጠቀምን፣ በትላልቅ ህትመቶች ወይም በብሬይል የተጻፉ ሰነዶችን፣ የድምፅ ቅጂዎችን ወይም ሌሎች መርጃዎችን ያለ ክፍያ ማቅረብን ይጩምራል። 1-855-903-2583 (TTY 711) ላይ ይደውሉ።	FRANÇAIS (French) ATTENTION : Si vous parlez Français, vous pouvez demander des services d'assistance linguistique gratuits. Si vous avez une déficience visuelle, auditive ou vocale, nous pouvons communiquer de la manière qui vous convient le mieux. Il peut s'agir d'interprètes en langue des signes, de documents en gros caractères ou en braille, d'enregistrements audio ou d'autres aides gratuites. Composez le 1-855-903-2583 (ATS 711).
LUS HMOOB (Hmong) LUS CEEV TSHWJ XEEB: Yog hais tias koj hais Lus Hmoob, koj tuaj yeem thov cov kev pab cuam uas pab hom lus tau dawb. Yog hais tias koj qhov muag tsis pom kev zoo, tsis hnov lus, los sis hais tsis tau lus, peb tuaj yeem sib txuas lus hauv ib txoj hau kev uas ua hauj lwm tau zoo tshaj plaws rau koj. Qhov no tej zaum yuav muaj xam nrog kev siv cov neeg txhais lus piav tes, kev muab cov ntaub ntawv luam tawm ua tus ntawv loj los sis Ua Ntawv Su Rau Cov Neeg Tsis Pom Kev Siv Tau (Braille), kev kaw ua suab lus, los sis lwm yam kev pab yam tsis tau them nqi. Hu rau 1-855-903-2583 (TTY 711).	SOOMALI (Somali) XASUUSIN: Haddii aad ku hadasho Soomali, waxaad codsan kartaa adeegyada caawimaadda luqada oo bilaash ah. Haddii aad laxaad la'aan kataahy aragga, maqalka, ama hadalka, waxaanu kugula xidhiidhi karnaa habka adiga kuugu habboon. Tan waxaa ka mid ah in aan isticmaalno turjumaanada luuqada dhegoolaha, in la bixiyo waraaqo ku qoran xarfaha waaweyn ama qoraalka indhoolayaasha, in la sameeyo cajalado la duubay, ama in la helo waxyaabo kale oo caawimaad ah oo bilaash ah. Wac 1-855-903-2583 (TTY 711).
ឌ្មែ (Khmer) ការដូនដំណីង៖ ្រសិនបរ ំអ៊ែននិយាយភាសា ខ្មែរ អនុតមាចបសន៍ស ំសវាដំនួយរកេវគេ ភាសាបោយឥតគិតថ្លៃ។ ្រសិនបរិ អនុតមេសិទីស ំសវាដំនួយរកវង្ករ ភាសាបោយឥតគិតថ្លៃ។ រសិនបរិ អនុតមេសិទិត ឬនិយាយមិនបាន បយ ំងអាចេប្រាស័យទាក់ទងដនាមួយអនុតតាមរបរៀរបេសេងសុងលមានហូរសិទធត ពលរសកសម្រោរ អនុ ពាលរសកសម្រោរ អនុ ការហ្បាបស្រ័យទាក់ទងបនៈហេដាចមានដូចជាអនុតរក8្សរ ភាសាសញ្ញា ការសាល់ឯកសារខ្តួលបបាេះពមណ្ឌ ្ររធំ ៗ ឬអ្កេរសាា រ ឬការលតទកជាស់ េា ្លង ឬជំនួយ បសេងបទៀត បោយឥតគិតថ្លៃ។ ទូរសពាបៅបលម 1-855-903-2583 (TTY 711)។	있습니다. 시각 장애, 청각 장애 또는 언어 장애가 있는 경우 저희는 귀하에게

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ကညီက ို ျKaren)	မြန်ာဘာသာ (Burmese)
ပ ာ်သ ာ်ပ ာ်သး- နမ ဏ တ ိၤ ကညီကိုျာ န ာ်, နဃ က ာ်ဂ ီ၀ တ ဏ စ	သတ ပပြုရနာ်- သင်ာသညာ် ပမနာ်မ ဘ သ စက းက ပပပ ပါက၊ အခမဲ ဘ သ စက း အက
ိၢမိၢစ ိၢလ တလ ာ်ဘ းလဲ သန ာ်လီၤိဳၤာနမ အာ ာ်ဒီးတ ဏာ လ တပ	အညီ ဝနာ်ပဆ င်ာမှုမ းက ပတ င်ားဆ နင်ာပါသညာ်။ သင်္ငတွင်ာ အပမင်ာအ ရ၊ အကက းအ ရ သမ
ဲိၤလ မဲ ာ်တဏ္ ာ်,တ်နာဏ္ ,မတမ ာ်တ်စ္းကတိၤတ်နာ်စ	ဟတာ် စက းပပပ ပခင်း ခ ြုုိုု္ပယ္ပင်းမှုရ ပနပါက သင်ာအတွကာ် အသငဘ်ပလ ာ်ဆ
ပဆဲးက ဆဲးက းတ ဏာ ကဲ က်ထီ ာ်လ တ်ထီ ာ်အေ၊ ကကာ ဏာ ကနာ ဖ	းပဖစ်ာမည်ာနည်ားလမ်ားပဖင်ာ ကျွနာ္်ဟ်တထသ ဆကာ်သွယာ်နင်ာပါသည်။ ၎င်ားတွင်ာ
ာ်လီၤိီၤႋ တ အာ ိၤ ပ ာ်ဃ ာ်ဒီး တ ်စ းကါ နီ ်ခ က ်ိဳ၀ ိၤက ာ်အပ ိၤက	လကာ်ဟနာ်ပပဘ သ စက း စက းပပနာ်မ းက အသ းပပြုပခင်း၊ စ ရွကာ်စ တမ်ားမ းက ပ န ဟ်စ
ာ်ထ တ ်စာ ဖ ာ်, တ ဖ်ာ ာ်လ ာ်လဲ ်စာ ဖ ာ်လ အလ ာ်ဖ ာ်ဖးဒ ာ်, မတမ	လ းကကီးမ း သမဟတာ် မ ကာ်မပမင်ာစ ပဖင်ာ
ာ်ပ ိၤမဲ ာ်ဘီ ာ်အလ ာ်,တ ်ာာလ အ်မတမ ာ်တ်ဓိၤစ ိၤဂ ိၢဂိၢတဖ ်စ	ပပ္းပပးပခင်္တး၊ အသဖမ်ားယပခင်္တးမ္း သမဟုတ် အပခ္းအပထုက်အကမ္းပဖင်္
လ တလ ာ်အဘ းလဲန ာ်လီးိီၤာ က းလီတဲစ ဆ 1-855-903-2583 (TTY 711) တက	အခမဲပပ္းပပ္းပခင်္ကးတ ပါဝင်ာပါသညာ်။ 1-855-903-2583 (TTY 711) သ ဖ နာ်းပခေါ်ဆ ပါ။
ီၤ•ာ်	
OROMOO (Oromo) Xiyyeeffannoon haa kennamu:- Oromo Afaan kan dubbatan yoo ta'e, tajaajiloota gargaarsa afaanii bilisaa gaafachuu ni dandeessu. Rakkoo ilaaluu, dhaga'u ykn dubbachuu yoo qabaattan, karaa isiniif mijatuun haala isiniif galuun mari'achuu ni dandeenya. Kunis of keessatti kan qabatu, hiiktota afaan mallattoo fayyadamuun maxxansa gurguddaa ykn bireeylii, waraabbiiwwan sagalee ykn gargaarsota biroo kaffaltii tokkoo malee gaafachuu dha. 1-855-903-2583 (TTY 711) irratti bilbilaa.	РУССКИЙ (Russian) ВНИМАНИЕ: Если ваш язык — РУССКИЙ, вы можете запросить бесплатные услуги языковой поддержки. Если у вас есть нарушение зрения, слуха или речи, мы можем общаться таким образом, который лучше всего подходит вам. Это может включать бесплатное использование переводчиков на языке жестов, предоставление документов крупным шрифтом или шрифтом Брайля, использование аудиозаписей или других вспомогательных средств. Звоните по телефону 1-855-903-2583 (TTY 711).
ພາສາລາວ (Lao) ເອົາໃຈໃສ່: ຖາ້ທ່ານເວົ້າ ພາສາລາວ, ທ່ານສາມາດຂໍບໍລິການຊ່ວຍເຫຼື ອດາ້ນພາສາໄດໂ້ດຍບໍ່ເສຍຄ່າ. ຖາ້ທ່ານມີຄວາມບົກຜ່ອງດາ້ນສາຍຕາ, ການໄດຍັນ ຫຼື ການປາກເວົ້າ, ພວກເຮົາສາມາດສ່ຼືສານດວ້ຍວິທີທີແໝາະສົມກັບທ່ານທີ່ສຸດ. ອັນນີອາດຈະລວມເຖິງການໃຊນ້າຍພາສາມື, ການຈັດກຽມເອກະສານເປັນໂຕພິມໃຫຍ່ ຫຼື ອັກສອນນູນ, ການບັນທຶກສຽງ ຫຼື ການຊ່ວຍເຫຼື ອດາ້ນສ່ຼືອ່ຼືນໆໂດຍບ່ ເສຍຄ່າໃຊຈ່ຳຍໃດໆ. ໂທ 1-855- 903-2583 (TTY 711).	Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang humingi ng mga libreng serbisyo na tulong sa wika. Kung may kapansanan ka sa paningin, pandinig, o pananalita, maaari tayong mag-usap sa paraan na pinakamabuti para sa iyo. Maaaring kabilang dito ang paggamit ng mga interpreter ng sign language, pagbibigay ng mga dokumento na malalaki ang pagkaprinta o Braille, mga audio recording, o iba pang mga tulong nang walang bayad. Tumawag sa 1-855-903-2583 (TTY 711).
VIETNAMESE (Vietnamese) LƯU Ý: Nếu quý vị nói Vietnamese, quý vị có thể yêu cầu dịch vụ hỗ trợ ngôn ngữ miễn phí. Nếu quý vị bị khiếm thị, khiếm thính hoặc khuyết tật về âm ngữ, chúng tôi có thể giao tiếp theo cách phù hợp nhất với quý vị. Điều này có thể bao gồm việc sử dụng thông dịch viên ngôn ngữ ký hiệu, cung cấp tài liệu dạng bản in cỡ chữ lớn hoặc chữ nổi, bản ghi âm hoặc các phương tiện hỗ trợ khác miễn phí. Xin gọi số 1-855-903-2583 (TTY 711).	简体中文 (Chinese Simplified) 注意:如果您说普通话,则可以免费申请语言协助服务。 如果您有视力、听力或语言障碍,我们可以用最适合您的方式与您交流。这可能 包括免费提供手语翻 译、大字体或盲文文件、录音或其他辅助工具。 请致电 1-855-903-2583(文字电话 711)。

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