BlueCross BlueShield Minnesota

2027

SUMMARY OF BENEFITS

Group Medicare Advantage Select with Rx Option 2 (PPO)

H5959

January 1, 2027 – December 31, 2027

Blue Cross® and Blue Shield® of Minnesota and Blue Plus® are nonprofit independent licensees of the Blue Cross and Blue Shield Association.

F11155R08 (08/26)

Introduction

This booklet includes an overview of Blue Cross and Blue Shield of Minnesota (Blue Cross) plan benefits, and a glossary of healthcare terms to help you learn more about this plan.

Group Medicare Advantage Benefits	Select with Rx Option 2
Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services	
Monthly Plan Premium	Please contact your previous employer, union or benefits administrator for premium information In addition, you must keep paying your monthly Medicare Part B premium
Annual Medical Deductible	$0
Out-of-Network cost sharing (unless otherwise specified)	Same as cost shares indicated in this grid
Maximum Out-of-Pocket Amount The following out-of-pocket limits applies: For services you receive from in-network and out-of-network providers Once you reach the annual maximum out-of-pocket amount, your plan pays 100% of covered medical services. Your plan premium and out-of-pocket costs for all other non-Medicare covered services do not count toward the annual maximum out-of-pocket amount.	$3,000
Covered Hospital and Medical Benefits	
Inpatient acute hospital care* (Medicare-covered)	$150 copay per stay
Inpatient hospital psychiatric care* (Medicare-covered)	$150 copay per stay
Skilled nursing facility (SNF) care* (Medicare-covered) This plan covers up to 100 days in a SNF	$0 per day for days 1 through 20 $0 per day for days 21 through 100
Meals following inpatient stay (Non-Medicare-covered) After an approved inpatient hospital or skilled nursing facility stay, we cover up to 2 meals per day for 14 days delivered to your home through the approved vendor Out-of-Network	$0 80% coinsurance up to the allowed benefit limit

* Benefits under this category may require prior authorization by the health plan.

Group Medicare Advantage Benefits	Select with Rx Option 2
Outpatient hospital care (Medicare-covered)	
Outpatient hospital surgery*	$150 copay
Ambulatory surgical center services*	$100 copay
Outpatient hospital all other services*	$0
Outpatient observation stay	$150 copay
Doctor's office visits (Medicare-covered)	
Primary care physician	$0
Specialist*	$20 copay
Preventive care (Medicare-covered) **See *Evidence of Coverage* for complete list of covered services.**	$0 This plan covers many preventive services, including but not limited to: • Annual wellness visit • Colorectal cancer screenings • Mammograms (breast cancer screening) • One-time "Welcome to Medicare" preventive visit Any additional preventive services approved by Medicare during the contract year will be covered
Preventive care (Non-Medicare-covered)	$0 Routine annual physical exam
Emergency care	
U.S. (Medicare-covered)	$50 copay
Worldwide (Non-Medicare-covered)	$50 copay
Urgent care	
U.S. (Medicare-covered)	$20 copay
Worldwide (Non-Medicare-covered)	$50 copay

* Benefits under this category may require prior authorization by the health plan.

Group Medicare Advantage Benefits	Select with Rx Option 2
Outpatient diagnostic tests and therapeutic services* (Medicare-covered)	
Diagnostic mammograms or colonoscopy	$0
Laboratory tests (e.g., A1C and Cholesterol tests)	$0
X-rays	$0
Diagnostic tests & procedures (excludes x-ray and advanced imaging) (e.g., EKG's, INR tests, pulmonary function tests, psychological/neuro-psychological testing, home or lab-based sleep studies)	$0
Diagnostic advanced imaging (e.g., specialized scans, CT, SPECT, PET, MRI, MRA, ultrasounds, angiograms)	$0
Radiation (e.g., treatment of cancer)	$0
Hearing services	
Medicare-covered exams to diagnose and treat hearing and balance issues	$0
Non-Medicare-covered routine hearing exam (limit 1)	$0
Out-of-Network	80% coinsurance
Non-Medicare-covered hearing aid exam (limit 1) through TruHearing	$0
Out-of-Network	80% coinsurance
Non-Medicare-covered prescription hearing aids (limit 2 aids per year, 1 per ear) through TruHearing	
Advanced Prescription Hearing Aid	$499 per aid
Premium Prescription Hearing Aid	$799 per aid
Rechargeable battery option is available on select styles	$0
Out-of-Network	80% coinsurance
Dental services* (Medicare-covered)	$20 copay

* Benefits under this category may require prior authorization by the health plan.

Group Medicare Advantage Benefits	Select with Rx Option 2
Routine Dental services* (Non-Medicare-covered)	
Prophylaxis and/or periodontal cleaning (limit 4) Oral exam (limit 2) Fluoride (limit 2) Dental x-rays (limit 1)	$0
Maximum plan benefit amount per year (combined in- and out-of-network)	$1,000
For covered services rendered by an out-of-network provider, you will be responsible for paying the difference between the provider fees and Blue Cross's Medicare out-of-network provider reimbursement rates, even for services listed as $0 copay. Out-of-Network reimbursement rates may vary by provider and service.	
Vision care	
Medicare-covered annual glaucoma screening, diabetic retinopathy, and exams to diagnose and treat eye diseases and conditions	$0
Medicare-covered eyewear after cataract surgery	$0
Non-Medicare-covered routine eye exam (limit 1 per year)	$0
Non-Medicare-covered, medically necessary prescription eyewear allowance for frames, lenses or contacts. Maximum allowance is per calendar year and may not be applied to eyewear received after cataract surgery.	
In- and Out-of-Network	$200 allowance per year
Mental healthcare* (Medicare-covered)	Your plan covers up to 190 days in a lifetime for inpatient mental healthcare in a psychiatric hospital This limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital
Inpatient visit	$150 copay per stay
Outpatient individual or group therapy visit	$20 copay
Partial hospitalization and intensive outpatient services	$55 copay per day

* Benefits under this category may require prior authorization by the health plan.

Group Medicare Advantage Benefits	Select with Rx Option 2
Mental health office visit* (Medicare-covered) Psychiatrist or psychologist	
Physical therapy services* (Medicare-covered) Physical, occupational and speech therapy visits	$20 copay
Ambulance* (ground and air, one way) (Medicare-covered) Worldwide Emergency Transportation (Non-Medicare-covered)	$75 copay 20% coinsurance
Ambulance services without transportation to a medical facility and other non- Medicare-covered transport services	Not covered
Medicare Part B prescription drugs (Medicare-covered) Part B oral chemotherapy and prescription drugs and all other Part B drugs* Part B insulin for use in an insulin pump	 Up to $35 copay for a one-month supply
Additional benefits and services	
Acupuncture* Medicare-covered acupuncture for chronic lower back pain (max. 20 visits every 12 months) Non-Medicare-covered routine acupuncture for pain diagnosis (max. 12 visits per year combined In- and Out-of-Network)	
Chiropractic services* Medicare-covered chiropractic services for manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position) Non-Medicare-covered routine chiropractic care (max. 12 visits per year combined In- and Out-of-Network, x-ray coverage not included)	

* Benefits under this category may require prior authorization by the health plan.

Group Medicare Advantage Benefits	Select with Rx Option 2
Diabetes self-management training, diabetic services and supplies (Medicare-covered)	
Diabetes monitoring supplies (coverage for test strips is limited to Ascensia brands)	$0
Diabetes self-management training	$0
Therapeutic shoes and inserts	$0
Preferred continuous glucose monitoring products*	10% coinsurance
Non-preferred continuous glucose monitoring products*	20% coinsurance
Durable medical equipment, prosthetic devices and medical supplies* (Medicare-covered)	
Durable medical equipment such as wheelchairs, walkers, oxygen equipment, etc.	10% coinsurance
Medical supplies such as braces, surgical dressings, splints, casts, etc.	10% coinsurance
Prosthetic devices, other than dental, such as artificial limbs, colostomy bags, etc.	10% coinsurance
Fitness program	$0
Gym membership at a participating SilverSneakers® facility, online fitness classes or choose a home exercise kit	
Out-of-Network	Up to a $15 reimbursement per month towards fitness facility membership
Home health agency care* (Medicare-covered)	$0
Medicare Diabetes Prevention Program (MDPP) (Medicare-covered) MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle	$0

* Benefits under this category may require prior authorization by the health plan.

Group Medicare Advantage Benefits	Select with Rx Option 2
Outpatient substance use disorder services* (Medicare-covered) Individual and group therapy visits	$20 copay
Over-The-Counter (OTC) items (Non-Medicare-covered) Quarterly allowance to spend on plan-approved OTC medications, items, services, and products. Remaining balance will not carry over to the next benefit period. This is not a reimbursement Out-of-Network	$50 80% coinsurance up to the allowed benefit limit
Peer support (Non-Medicare-covered) Connect with a peer support specialist who has firsthand experience with mental health and substance abuse care for mentorship that supports recovery	$0
Podiatry services* (Medicare-covered) Foot exams and treatment for diabetes-related nerve damage or certain medical conditions	$20 copay
Services to treat kidney disease (Medicare-covered) Renal dialysis services* Kidney disease education services	 $0 $0
Tobacco use and vaping cessation Counselling to stop smoking, vaping or tobacco use	$0

* Benefits under this category may require prior authorization by the health plan.

Medicare Part D prescription drug coverage

This Blue Cross Group Medicare Advantage plan provides combined medical and prescription drug coverage to give you the convenience of one plan, one card and one bill. To view which drugs are covered by this plan, visit bluecrossmn.com/Drugs. Select Group Medicare Advantage (PPO) – CMS H5959 801, 809 and click continue. Then you can either search by drug name or scroll halfway down to Helpful documents to view the comprehensive formulary.

In addition, the Medicare Prescription Payment Plan is a payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across monthly payments that vary throughout the year (January – December).

To learn more about this payment option, please contact us at 1-833-692-8013 (TTY: 711) or visit medicare.gov.

	Group Medicare Advantage Benefits	**Select with Rx Option 2**
	Deductible	$0
	Initial Coverage	**Standard/LTC[2] Cost-Sharing**
31-Day Supply from a Network Pharmacy	Tier 1: Preferred Generic Drugs	$0
	Tier 2: Generic Drugs	$10 copay
	Tier 3: Preferred Brand Drugs	$25 copay
	Tier 4: Non-Preferred Drugs	$60 copay
	Tier 5: Specialty Drugs	25% coinsurance
	Insulin Coverage	Up to a $35 copay
60–90-Day Supply from a Network or Mail Order Pharmacy	Tier 1: Preferred Generic Drugs	$0
	Tier 2: Generic Drugs	$20 copay
	Tier 3: Preferred Brand Drugs	$50 copay
	Tier 4: Non-Preferred Drugs	$120 copay
	Tier 5: Specialty Drugs	25% coinsurance
	Insulin Coverage	Up to a $70 copay
	Catastrophic Coverage Begins once your total out-of-pocket costs for the year reach $2,400[1]	$0
	Supplemental drugs	25% coinsurance

[1]You'll pay no more than $2,400 for covered drugs during the calendar year. This amount is calculated based on the defined standard Part D drug benefit. Review your Explanation of Benefits documents to track the amounts being applied toward the catastrophic coverage limit.

[2]If in Long-Term Care facility (LTC), up to a 31-day supply only.

Pre-enrollment checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, please contact your Group Administrator.

Understanding the benefits

- [ ] The *Evidence of Coverage* (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Please contact your Group Administrator for information on how to receive a copy of the EOC.
- [ ] Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- [ ] Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- [ ] Review the formulary to make sure your drugs are covered.

Understanding important rules

- [ ] In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- [ ] Benefits, premiums and/or copayments/coinsurance may change on January 1, 2028.
- [ ] Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you may pay a higher portion of the cost for services received from non-contracted providers. Non-contracted providers are not required to submit claims directly to Blue Cross. You may need to pay for services and file a claim with Blue Cross for reimbursement.
- [ ] Effect on current coverage: If you are currently enrolled in a Medicare Advantage plan and/or Medicare Part D prescription drug plan, your current Medicare Advantage coverage and/or Part D coverage will end once your new Medicare Advantage coverage starts. If you have TRICARE, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact TRICARE for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.

Frequently asked questions

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, contact your Group Administrator and ask for the *Evidence of Coverage*.

Who can enroll?

You can enroll in Group Medicare Advantage (PPO) if you meet eligibility requirements determined by your previous employer, union or benefits administrator, are entitled to Medicare Part A and enrolled in Medicare Part B and live in the plan availability area. The plan availability area includes the United States and all U.S. Territories.

What is group Medicare Advantage?

Group Medicare Advantage plans are private Medicare health plans. They have a yearly limit on your out-of-pocket costs for covered services, and once you reach this limit, you'll pay nothing for covered services. Some Group Medicare Advantage plans combine medical and prescription drug coverage.

How do I find an in-network doctor or hospital?

You can see or order the plan's provider directory at bluecrossmn.com/Medicare-Documents. You can also search online at bluecrossmn.com/MedicareFAD and selecting the Group Medicare Advantage network.

How can I find a list of covered drugs?

You can see the complete *Formulary* (list of Part D prescription drugs) and any restrictions at bluecrossmn.com/Drugs under Group Medicare Advantage (PPO) – CMS H5959 801, 809.

How much will I need to pay for prescription drugs?

The amount you pay depends on what tier the drug is in and what benefit stage you have reached. Your costs for each drug tier and benefit stage are shown in the benefit chart previously in this summary.

When using in-network pharmacies you will typically see lower prices than using out-of-network pharmacies for covered Part D drugs.

You can also save costs when you choose 90-day supplies from certain pharmacies and mail-order pharmacies.

You can find the most updated list of pharmacies in your area at bluecrossmn.com/Pharmacy under Group Medicare Advantage (PPO) – CMS H5959 801, 809.

What are the drug benefit stages?

As you spend up to certain dollar amounts on your covered prescription drugs, you will move into different benefit stages.

Stage 1: Meet your deductible This is the amount you must pay each year for prescriptions before the plan will begin to pay its share of your covered drugs.

Stage 2: Initial coverage Once you've met your deductible, you'll pay a copay or coinsurance until the amount spent by you and your plan on your covered drugs reaches the initial coverage limit set by Medicare for that year.

Stage 3: Catastrophic coverage Once you enter the catastrophic coverage stage, you will not have any cost share for the rest of the year, except for supplemental drugs.

Find plan documents at bluecrossmn.com/Medicare-Documents or by logging in to your online member account at bluecrossmn.com/AccountLogin. You can also call your group administrator to request a copy.

Healthcare terms

Allowed amount – The contracted rate, or Blue Cross discount, set by your plan and providers when you use in-network hospitals, clinics or pharmacies. Providers are required to accept the allowed amount as payment in full and cannot charge above it when you see an in-network provider.

Annual physical exam – A yearly preventive visit with your primary care doctor that includes a discussion about your health, a review of your medical history, screenings, immunizations and some lab work.

Coinsurance – A set percentage you pay toward healthcare or prescription drugs.

Copayment or Copay – The set dollar amount you pay each time you receive a service or prescription.

Deductible – Amount you will pay in one plan year before coverage begins.

In-network – The hospitals, clinics, providers and pharmacies that are included in your plan. Typically, using in-network providers results in lower member costs.

Maximum out-of-pocket amount – The most you could pay in one plan year for covered medical services and supplies.

Medicare annual wellness visit – An annual visit with your doctor after you've been enrolled in Medicare Part B for at least 12 months. This visit includes a review of your medical history, screenings and personalized health advice, and a checklist of appropriate preventive services.

Out-of-network – The hospitals, and clinics and pharmacies that are not included in your plan.

Out-of-pocket costs – The amount you must pay for eligible healthcare. It includes copays, coinsurance and deductibles, plus any costs for care that is not covered. It does not include your monthly premiums.

Premium – Your monthly payment for a plan.

Prior authorization – Approval in advance to receive certain services or certain drugs.

Total charge – The amount the provider or pharmacy charges for services before a Blue Cross discount (allowed amount) is applied.

Welcome to Medicare visit – A one-time preventive visit within the first 12 months of your new Medicare Part B plan. This visit includes a review of your medical history, screenings, vaccinations and a discussion of preventive services available to you that you may need.

Notice of Nondiscrimination and Accessibility

At Blue Cross and Blue Shield of Minnesota and Blue Plus, 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.com
Telephone: 1-800-509-5312
Mail: 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 bluecrossmn.com/NDL, 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).

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)
تنبيه: إذا كنت تتحدث العربية، يمكنك الحصول على 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 1-855-903-2583 (الهاتف النصي 711).

አማርኛ (Amharic)
ትኩረት ይሰጥ፦ አማርኛ ቋንቋ የሚናገሩ ከሆነ፣ ነጻ የቋንቋ እገዛ አገልግሎቶችን መጠየቅ ይችላሉ። የማየት፣ የመስማት ወይም የመናገር ችግር ካለብዎት ለእርስዎ በተሻለ በሚሠራው መንገድ መግባባት እንችላለን። ይህ ደግሞ የምልክት ቋንቋ አስተርጓሚዎችን መጠቀምን፣ በትላልቅ ህትመቶች ወይም በብሬይል የተጻፉ ሰነዶችን፣ የድምፅ ቅጂዎችን ወይም ሌሎች መርጃዎችን ያለ ክፍያ ማቅረብን ይጨምራል። 1-855-903-2583 (TTY 711) ላይ ይደውሉ።

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).

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)。

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）。

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).

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).

ខ្មែរ (Khmer)
ការជូនដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសា ខ្មែរ អ្នកអាចស្នើសុំសេវាជំនួយបកប្រែភាសាដោយឥតគិតថ្លៃ។ ប្រសិនបើអ្នកមើលមិនឃើញ ស្តាប់មិនឮ ឬនិយាយមិនបាន យើងអាចប្រាស្រ័យទាក់ទងជាមួយអ្នកតាមរបៀបផ្សេងដែលមានប្រសិទ្ធភាពល្អបំផុតសម្រាប់អ្នក។ ការប្រាស្រ័យទាក់ទងនេះអាចមានដូចជាអ្នកបកប្រែភាសាសញ្ញា ការផ្តល់ឯកសារដែលបោះពុម្ពអក្សរធំៗ ឬអក្សរស្ទាប ឬការថតទុកជាសំឡេង ឬជំនួយផ្សេងទៀត ដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-855-903-2583 (TTY 711)។

한국어 (Korean)
주의: 한국어를 사용하시는 경우 귀하는 무료 언어 지원 서비스를 요청하실 수 있습니다. 시각 장애, 청각 장애 또는 언어 장애가 있는 경우 저희는 귀하에게 가장 적합한 방법으로 연락을 드릴 수 있습니다. 여기에는 수화통역사 이용, 대형 활자 또는 점자로 작성된 문서 제공, 음성 녹음 또는 기타 무료 지원이 포함될 수 있습니다. 1-855-903-2583 (TTY 711) 번으로 전화하십시오.

ကညီကျိာ် (Karen)

ဟ်သူဉ်ဟ်သး- နမ့ၢ်ကတိၤ ကညီကျိာ် နှဉ်,
နဃ့ကျိာ်ဂ့ၢ်ဝီတၢ်တိစၢၤမၤစၢၤလၢတလၫ်ဘူးလဲ သ့နှဉ်လီၤ.
နမ့ၢ်အိဉ်ဒီးတၢ်တလၢတပှဲၤလၢ မဲာ်တၢ်ထံဉ်, တၢ်နၢ်ဟူ, မ့တမ့ၢ်
တၢ်စံးကတိၤတၢ်နှဉ် ပဆဲးကျၢဆဲးကျိုးတၢ်လၢ
ကျဲကဲထိဉ်လိာ်ထိဉ်အဂ့ၤကတၢ်ၢ်လၢနဂီၢ်သ့နှဉ်လီၤ. တၢ်အံၤ
ပဉ်ဃာ်ဒီး တၢ်စူးကါ နီၢ်ခိက့ၢ်ဂီၤကျိာ်အပှၤကျိာ်ထံတၢ်တဖဉ်,
တၢ်ဟ့ဉ်လံာ်လံၢ်တဖဉ်လၢ အလံာ်ဖျၢဉ်ဖးဒိဉ်, မ့တမ့ၢ်
ပှၤမဲာ်ဘျိဉ်အလံာ်, တၢ်ကလုၢ်, မ့တမ့ၢ် တၢ်မၤစၢၤဂုၤဂၤတဖဉ်
လၢတလၫ်အဘူးလဲနှဉ်လီၤ. ကိးလီတဲစိဆူ
1-855-903-2583 (TTY 711) တက့ၢ်.

မြန်မာဘာသာ (Burmese)

သတိပြုရန်- သင်သည် မြန်မာဘာသာ စကားကို ပြောပါက၊
အခမဲ့ ဘာသာစကား အကူအညီ ဝန်ဆောင်မှုများကို
တောင်းဆိုနိုင်ပါသည်။ သင့်တွင် အမြင်အာရုံ၊ အကြားအာရုံ၊
သို့မဟုတ် စကားပြောခြင်း ချို့ယွင်းမှုရှိနေပါက သင့်အတွက်
အသင့်လျော်ဆုံးဖြစ်မည့်နည်းလမ်းဖြင့် ကျွန်ုပ်တို့ထံသို့
ဆက်သွယ်နိုင်ပါသည်။ ၎င်းတွင် လက်ဟန်ပြဘာသာစကား
စကားပြန်များကို အသုံးပြုခြင်း၊ စာရွက်စာတမ်းများကို
ပုံနှိပ်စာလုံးကြီးများ သို့မဟုတ် မျက်မမြင်စာဖြင့် ပံ့ပိုးပေးခြင်း၊
အသံဖမ်းယူခြင်းများ သို့မဟုတ်
အခြားအထောက်အကူများဖြင့် အခမဲ့ပံ့ပိုးပေးခြင်းတို့
ပါဝင်ပါသည်။ 1-855-903-2583
(TTY 711) သို့ ဖုန်းခေါ်ဆိုပါ။

OROMOO (Oromo)

Xiyyeeffannoon haa kennamuː- 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: ຖ້າທ່ານເວົ້າ ພາສາລາວ,
ທ່ານສາມາດຂໍບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໄດ້ໂດຍບໍ່ເສຍຄ່າ.
ຖ້າທ່ານມີຄວາມບົກຜ່ອງດ້ານສາຍຕາ, ການໄດ້ຍິນ ຫຼື
ການປາກເວົ້າ,
ພວກເຮົາສາມາດສື່ສານດ້ວຍວິທີທີ່ເໝາະສົມກັບທ່ານທີ່ສຸດ.
ອັນນີ້ອາດຈະລວມເຖິງການໃຊ້ນາຍພາສາມື,
ການຈັດກຽມເອກະສານເປັນໂຕພິມໃຫຍ່ ຫຼື ອັກສອນນູນ,
ການບັນທຶກສຽງ ຫຼື
ການຊ່ວຍເຫຼືອດ້ານສື່ອື່ນໆໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍໃດໆ. 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).

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