# PEIP Advantage HSA Single Plan Cost Level 3

## Blue Cross Blue Shield of Minnesota

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

**Coverage Period: Beginning on or after 01/01/2027**
**Coverage for: Individual | Plan Type: PPO**

**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 bluecrossmn.com or call 1-866-873-5943. 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 https://www.healthcare.gov/sbc-glossary or call 1-866-873-5943 to request a copy.

- **Out of Network**. This plan does not cover services with out-of-network providers, except for Emergency and Urgent Care. All services must be coordinated with the Primary Care Clinic (PCC).

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | $3,250 individual medical and drug in-network | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. |
| **Are there services covered before you meet your deductible?** | Yes. Well child care, prenatal care and in-network preventive care services 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 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?** | $4,250 individual medical and drug in-network | The out-of-pocket limit is the most you could pay in a year for covered services. |
| **What is not included in the out-of-pocket limit?** | 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 out-of-pocket limit. |
| **Will you pay less if you use an in-network provider?** | Yes. See bluecrossmn.com/find-a-doctor/#/home or call 1-866-873-5943 for a list of in-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 in-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?** | Yes | This plan will pay some or all fo the costs to see a specialist for covered services but only if you have a referral before you see the specialist. |

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

| Common Medical Event | Services You May Need | What you Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $105 copay/office visit | Not covered | None |
| | Specialist visit | $105 copay/office visit | Not covered | None |
| | 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. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 30% coinsurance | Not covered | May require prior authorization. |
| | Imaging (CT/PET scans, MRIs) | 30% coinsurance | Not covered | |
| **If you need drugs to treat your illness or condition.** More information about prescription drug coverage is available at www.caremark.com | Preferred generic drugs | $30.00 copay/retail<br>$60.00 copay/mail service<br>$60.00 copay/90dayRx retail | Not covered | For additional information on your prescription drug benefits, please refer to your prescription drug Pharmacy Benefit Manager.<br>May require prior authorization. |
| | Preferred brand drugs | $50.00 copay/retail<br>$100.00 copay/mail service<br>$100.00 copay/90dayRx retail | Not covered | |
| | Non-preferred drugs | $75.00 copay/retail<br>$150.00 copay/mail service<br>$150.00 copay/90dayRx retail | Not covered | |
| | Specialty drugs | Refer to applicable prescription drug cost sharing | Not covered | For additional information on your prescription drug benefits, please refer to your prescription drug Pharmacy Benefit Manager. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $800 copay/surgery | Not covered | May require prior authorization. |
| | Physician/surgeon fees | No charge | Not covered | |
| **If you need immediate medical** | Emergency room care | $350 copay/visit | $350 copay/visit | None |

| Common Medical Event | Services You May Need | What you Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **attention** | Emergency medical transportation | 30% coinsurance | 30% coinsurance | |
| | Urgent care | $105 copay/visit | $105 copay/visit | Out-of-network services applies to in-network deductible and out-of-pocket limit. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $1,500 copay/admission | Not covered | None |
| | Physician/surgeon fee | No charge | Not covered | None |
| **If you need mental health, behavioral health, or substance use services** | Outpatient services | $75 copay/visit | Not covered | Services for marriage/couples counseling are not covered. May require prior authorization. |
| | Inpatient services including adult mental health treatment | $1,500 copay/admission | Not covered | |
| **If you are pregnant** | Office visits | Prenatal care: No charge<br>Postnatal care: No charge | Not covered | Cost-sharing does not apply for preventive services. Depending on the type of services, other cost-sharing may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound). |
| | Childbirth/delivery professional services | No charge | Not covered | |
| | Childbirth/delivery facility services | $1,500 copay/admission | Not covered | |
| **If you need help recovering or have other special health needs** | Home health care | 30% coinsurance | Not covered | May require prior authorization. |
| | Rehabilitation services | $105 copay for occupational therapy, physical therapy, and speech therapy | Not covered | May require prior authorization. |
| | Habilitation services | $105 copay for occupational therapy, physical therapy, and speech therapy | Not covered | |
| | Skilled nursing care | No charge after deductible | Not covered | 180-day maximum applies for all networks. 2 per hospice episode maximum per lifetime for all networks. May require prior authorization. |

| Common Medical Event | Services You May Need | What you Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Durable medical equipment | 30% coinsurance | Not covered | May require prior authorization. |
| | Hospice service | No charge after deductible | Not covered | None |
| **If your child needs dental or eye care** | Children's eye exam | No charge | Not covered | None |
| | 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 Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Cosmetic surgery
- Dental care (Adult) (and children)
- 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 apply to these services. This isn't a complete list. Please see your plan document.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- 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, visit 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 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 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: 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 www.dol.gov/ebsa/healthreform. If you are covered under a plan 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.

## Notice of Nondiscrimination Practices

***Effective July 18, 2016***

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender. Blue Cross does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

Blue Cross provides resources to access information in alternative formats and languages:

- Auxiliary aids and services, such as qualified interpreters and written information available in other formats, are available free of charge to people with disabilities to assist in communicating with us.
- Language services, such as qualified interpreters and information written in other languages, are available free of charge to people whose primary language is not English.

If you need these services, contact us at 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711.

If you believe that Blue Cross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or gender, you can file a grievance with the Nondiscrimination Civil Rights Coordinator

- by email at: Civil.Rights.Coord@bluecrossmn.com
- by mail at: Nondiscrimination Civil Rights Coordinator
  Blue Cross and Blue Shield of Minnesota and Blue Plus
  M495
  PO Box 64560
  Eagan, MN 55164-0560
- or by telephone at: 1-800-509-5312

Grievance forms are available by contacting us at the contacts listed above, by calling 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711. If you need help filing a grievance, assistance is available by contacting us at the numbers listed above.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights

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

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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 Baby
(9 months of in-network prenatal care and a hospital delivery)

| | |
|---|---|
| The plan's overall deductible | **$3,250** |
| Specialist copayment | **$105** |
| Hospital (facility) coinsurance | **0%** |
| Other coinsurance | **30%** |

**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 | $3,250 |
| Copayments | $1,000 |
| Coinsurance | $0 |
| ***What isn't covered*** | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$4,310** |

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

| | |
|---|---|
| The plan's overall deductible | **$3,250** |
| Specialist copayment | **$105** |
| Hospital (facility) coinsurance | **0%** |
| Other coinsurance | **30%** |

**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 | $1,900 |
| Copayments | $200 |
| Coinsurance | $0 |
| ***What isn't covered*** | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$2,120** |

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

| | |
|---|---|
| The plan's overall deductible | **$3,250** |
| Specialist copayment | **$105** |
| Hospital (facility) coinsurance | **0%** |
| Other coinsurance | **30%** |

**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 | $2,400 |
| Copayments | $10 |
| Coinsurance | $0 |
| ***What isn't covered*** | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,410** |

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

## 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 tratis, 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 MinnesotaATTN: 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, available at: ocrportal.hhs.gov/ocr/portal/lobb.jsf
- by mail at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 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.

| | |
|---|---|
| **ENGLISH**<br>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)**<br>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)**<br>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)**<br>تنبيه: 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 1-855-903-2583 (الهاتف النصي 711). |
| **አማርኛ (Amharic)**<br>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። | **FRANÇAIS (French)**<br>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)**<br>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)**<br>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). |
| **ខ្មែរ (Khmer)**<br>ការជូនដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសា ខ្មែរ អ្នកអាចស្នើសុំសេវាជំនួយបកប្រែភាសាដោយឥតគិតថ្លៃ។ ប្រសិនបើអ្នកមើលមិនឃើញ ស្តាប់មិនឮ ឬនិយាយមិនបាន យើងអាចប្រាស្រ័យទាក់ទងជាមួយអ្នកតាមរបៀបផ្សេងដែលមានប្រសិទ្ធភាពល្អបំផុតសម្រាប់អ្នក។ ការប្រាស្រ័យទាក់ទងនេះអាចមានដូចជាអ្នកបកប្រែភាសាសញ្ញា ការផ្តល់ឯកសារដែលបោះពុម្ពអក្សរធំៗ ឬអក្សរស្តាប ឬការថតទុកជាសំឡេង ឬជំនួយផ្សេងទៀត ដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-855-903-2583 (TTY 711)។ | **한국어 (Korean)**<br>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. |

| | |
|---|---|
| **ကညီကျိ် (Karen)**<br>ဟ်သူဉ်ဟ်သး- နမ့ၢ်ကတိၤ ကညီကျိ် နၣ်, နဃ့ကျိ်ဂ့ၢ်ဝီတၢ်တိစၢၤမၤစၢၤလၢတလၢ်ဘူးလဲသ့နၣ်လီၤ. နမ့ၢ်အိဉ်ဒီးတၢ်တလၢတပှဲၤလၢ မဲာ်တၢ်ထံဉ်, တၢ်နၢ်ဟူ, မ့တမ့ၢ် တၢ်စံးကတိၤတၢ်နၣ်ပဆဲးကျၢဆဲးကျိုးတၢ်လၢ ကျဲကဲထီဉ်လိာ်ထီဉ်အဂ့ၤကတၢၢ်လၢနဂီၢ်သ့နၣ်လီၤ. တၢ်အံၤ ပဉ်ဃုာ်ဒီးတၢ်စူးကါ နီၢ်ခိကွ့ၢ်ဂီၤကျိ်အပှၤကျိ်ထံတၢ်တဖဉ်, တၢ်ဟ့ဉ်လံာ်လဲၢ်တဖဉ်လၢ အလံာ်ဖျၢဉ်ဖးဒိဉ်, မ့တမ့ၢ် ပှၤမဲာ်ဘျိဉ်အလံာ်, တၢ်ကလုၢ်, မ့တမ့ၢ် တၢ်မၤစၢၤဂုၤဂၤတဖဉ် လၢတလၢ်အဘူးလဲနၣ်လီၤ. ကိးလီတဲစိဆူ 1-855-903-2583 (TTY 711) တကွ့ၢ်. | **မြန်မာဘာသာ (Burmese)**<br>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 မျက်မြင်စာဖြင့် ပံ့ပိုးပေးခြင်း၊ အသံဖမ်းယူခြင်းများ သို့မဟုတ် အခြားအထောက်အကူများဖြင့် အခမဲ့ပံ့ပိုးပေးခြင်းတို့ ပါဝင်ပါသည်။ 1-855-903-2583 (TTY 711) သို့ ဖုန်းခေါ်ဆိုပါ။ |
| **OROMOO (Oromo)**<br>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)**<br>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)**<br>ເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າ ພາສາລາວ, ທ່ານສາມາດຂໍບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໄດ້ໂດຍບໍ່ເສຍຄ່າ. ຖ້າທ່ານມີຄວາມບົກຜ່ອງດ້ານສາຍຕາ, ການໄດ້ຍິນ ຫຼື ການປາກເວົ້າ, ພວກເຮົາສາມາດສື່ສານດ້ວຍວິທີທີ່ເໝາະສົມກັບທ່ານທີ່ສຸດ.<br>ອັນນີ້ອາດຈະລວມເຖິງການໃຊ້ນາຍພາສາມື, ການຈັດກຽມເອກະສານເປັນໂຕພິມໃຫຍ່ ຫຼື ອັກສອນນູນ, ການບັນທຶກສຽງ ຫຼື ການຊ່ວຍເຫຼືອດ້ານສື່ອື່ນໆໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍໃດໆ. ໂທ 1-855-903-2583 (TTY 711). | **Tagalog (Tagalog)**<br>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)**<br>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)**<br>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）。 |