


Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services Allianz Life Coupe Health

Coverage Period: 01/01/2025 – 12/31/2025

Coverage For: Individual + Family 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, call your Coupe Health Valet at 1-833-749-1969 or visit us at coupehealth.com. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance after overall deductible](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-833-749-1969 to request a copy.

| Important Questions | Answers | | Why This Matters: |
|---------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall deductible ? | <p>Tier 1-3 In-Network There is no deductible.</p> | <p>Tier 4 Out-of-Network No Coverage</p> | There is no overall deductible for this plan . |
| Are there services covered before you meet your deductible ? | <p>Tier 1 In-Network Yes. There is no overall calendar year deductible.</p> | <p>Tier 4 Out-of-Network No Coverage</p> | There is no overall deductible for this plan. But a copayment may apply. For example, this plan covers certain preventive services without cost-sharing . 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 a deductible for specific services. |
| What is the out-of-pocket limit for this plan ? | <p>Tier 1-3 In-Network \$3,250 / individual \$6,500 / family</p> | <p>Tier 4 Out-of-Network No Coverage</p> | 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 limit until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit ? | Premiums , balance billed charges, health care this plan doesn't cover, cost sharing for most out-of-network benefits, and pre-certification penalties. | | 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 coupehealth.com or call 1-833-749-1969 for a list of network providers . | | This plan uses a provider network. No out-of-network coverage. 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 . |

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 | Tier 1 - 3 In-Network | | | Tier 4 Out-of-Network | 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 | \$20 copay | \$25 copay | \$40 copay | Not Covered | Precertification may be required for some provider administered drugs; if no precertification is obtained, no benefits are available; primary care visits includes Retail Health Clinics, E-Visits, Telehealth and Telephone; no Charge for Doctor on Demand. |
| | Specialist visit | \$40 copay | \$50 copay | \$80 copay | Not 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. Please call your Coupe Health Valet at 1-833-749-1969 to confirm benefits. |
| If you have a test | Diagnostic test (x-ray, blood work) | Diagnostic Radiology/ Diagnostic Labs: \$45 copay Basic Labs: \$10 copay | Diagnostic Radiology/ Diagnostic Labs: \$60 copay Basic Labs: \$15 copay | Diagnostic Radiology/ Diagnostic Labs: \$105 copay Basic Labs: \$25 copay | Not Covered | Fee listed is for diagnostic labs, x-rays and radiology and include facility and physician charges; precertification may be required for some services. |
| | Imaging (CT/PET scans, MRIs) | \$185 copay | \$245 copay | \$410 copay | Not Covered | None |

* For more information about limitations and exceptions, see the [plan](#) or policy document at [coupehealth.com](#)

| Common Medical Event | Services You May Need | Tier 1 - 3 In-Network | | | Tier 4 Out-of-Network | Limitations, Exceptions, & Other Important Information |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|-----------------------------|-------------------------------|-----------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at coupehealth.com | Tier 1 (Generic Drugs) | \$10 copay (retail) \$25 copay (mail order) \$25 copay (90 day Rx retail) | | | Not Covered | Prior authorization may be required for some drugs; if prior authorization is not obtained, no benefits are available. |
| | Tier 2 (Non-Preferred Generic Drugs) | \$75 copay (retail) \$150 copay (mail order) \$150 copay (90 day Rx retail) | | | Not Covered | |
| | Tier 3 (Preferred Brand Drugs) | \$35 copay (retail) \$70 copay (mail order) \$70 copay (90 day Rx retail) | | | Not Covered | |
| | Tier 4 (Non-Preferred Brand Drugs) | \$75 copay (retail) \$150 copay (mail order) \$150 copay (90 day Rx retail) | | | Not Covered | |
| | Tier 5 (Specialty Drugs) | \$125 copay (retail) | | | Not Covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | \$600 copay | \$800 copay | \$1,355 copay | Not Covered | Facility fee listed includes facility and physician charges associated with outpatient facility and surgical services. |
| | Physician/surgeon fees | No Charge | | | Not Covered | Physician charges associated with outpatient facility and surgical services are included in the facility charges listed in the section above. |
| If you need immediate medical attention | Emergency room care | \$250 copay | | | | Facility fee listed includes facility and physician charges associated with medical emergency services; no copay for Prenatal complications; no copay for Maternity complications; copay waived if admitted within 24 hours; services apply to tier 1-3 out-of-pocket maximum. |
| | Emergency medical transportation | \$250 copay | | | | Services apply to tier 1-3 out-of-pocket maximum. |

* For more information about limitations and exceptions, see the [plan](#) or policy document at coupehealth.com

| Common Medical Event | Services You May Need | Tier 1 - 3 In-Network | | | Tier 4 Out-of-Network | Limitations, Exceptions, & Other Important Information |
|---------------------------------------------------------------------------|-------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-----------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | Urgent care | \$75 copay | | | Not Covered | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$1,655 copay | \$2,210 copay | \$3,200 copay | Not Covered | Facility fee listed includes facility and physician charges associated with inpatient services; precertification is required. |
| | Physician/surgeon fees | No Charge | | | Not Covered | Physician charges associated with inpatient services are included in the facility charges listed in the section above |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Physician's Office: No Charge Outpatient: \$20 copay | Physician's Office: No Charge Outpatient: \$25 copay | Physician's Office: No Charge Outpatient: \$40 copay | Not Covered | Facility fee listed for inpatient services includes facility and physician. |
| | Inpatient services | \$1,655 copay | \$2,210 copay | \$3,200 copay | Not Covered | |
| If you are pregnant | Office visits | Prenatal Care: No Charge Postnatal Care: \$20 copay | Prenatal Care: No Charge Postnatal Care: \$25 copay | Prenatal Care: No Charge Postnatal Care: \$40 copay | Not Covered | Cost sharing does not apply for preventive services . Depending on the type of services, a copayment may be required. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); facility fee listed includes facility and physician services associated with maternity facility services; office visit copay applies to initial office visit to determine pregnancy. |
| | Childbirth/delivery professional services | No Charge | | | Not Covered | |
| | Childbirth/delivery facility services | \$1,655 copay | \$2,210 copay | \$3,200 copay | Not Covered | |

* For more information about limitations and exceptions, see the [plan](#) or policy document at [coupehealth.com](#)

| Common Medical Event | Services You May Need | Tier 1 - 3 In-Network | | | Tier 4 Out-of-Network | Limitations, Exceptions, & Other Important Information |
|-----------------------------------------------------------------------|-------------------------------------------|-------------------------------|-------------------------------|-------------------------------|-----------------------|-------------------------------------------------------------------------------------------|
| If you need help recovering or have other special health needs | Home health care | \$40 copay | \$50 copay | \$80 copay | Not Covered | Precertification may be required; benefits are also available for home infusion services. |
| | Rehabilitation services | \$20 copay | \$25 copay | \$40 copay | Not Covered | None |
| | Habilitation services | \$20 copay | \$25 copay | \$40 copay | Not Covered | |
| | Skilled nursing care | \$1,450 copay | \$1,930 copay | \$3,200 copay | Not Covered | Precertification may be required. |
| | Durable medical equipment | \$85 copay | \$110 copay | \$185 copay | Not Covered | Precertification may be required. |
| | Hospice services | \$200 copay | \$265 copay | \$445 copay | Not Covered | Precertification may be required. |
| If your child needs dental or eye care | Children's eye exam | No Charge | | | Not Covered | None |
| | Children's glasses | Not Covered | | | Not Covered | Not covered; member pays 100% |
| | Children's dental check-up | No Charge | | | Not Covered | None |

* For more information about limitations and exceptions, see the [plan](#) or policy document at [coupehealth.com](#)

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](#).)

- Acupuncture (except as specified in plan benefits)
- Cosmetic surgery (except as specified in plan benefits)
- Dental care (except as specified in plan benefits)
- Long-term care
- Medications not on the covered list unless an exception is obtained
- 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.)

- Bariatric surgery (limitations apply)
- Chiropractic care
- Hearing Aids (limitations apply)
- Infertility Treatment (limitations apply)
- Non-emergency care when traveling outside the U.S.
- 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa> or your [plan](#) administrator at the phone number listed in your benefit booklet. 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: Your [plan](#) administrator at the phone number listed in your benefit booklet. You may also contact Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>.

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 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](#).

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

| Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery) | | Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition) | | Mia's Simple Fracture (in-network emergency room visit and follow up care) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| ■ The plan's overall deductible | \$0 | ■ The plan's overall deductible | \$0 | ■ The plan's overall deductible | \$0 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ■ Specialist copayment | \$40 | ■ Specialist copayment | \$40 | ■ Specialist copayment | \$40 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ■ Hospital (facility) copayment | \$1,655 | ■ Hospital (facility) copayment | \$1,655 | ■ Hospital (facility) copayment | \$1,655 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ■ Other copayment | \$250 | ■ Other copayment | \$250 | ■ Other copayment | \$250 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)</p> | | <p>This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)</p> | | <p>This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic tests (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Total Example Cost | \$12,700 | Total Example Cost | \$5,600 | Total Example Cost | \$2,800 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>In this example, Peg would pay:</p> <table border="1"> <thead> <tr> <th colspan="2">Cost Sharing</th> </tr> </thead> <tbody> <tr> <td>Deductibles</td> <td>\$0</td> </tr> <tr> <td>Copayments</td> <td>\$2,200</td> </tr> <tr> <td>Coinsurance</td> <td>\$0</td> </tr> <tr> <th colspan="2">What isn't covered</th> </tr> <tr> <td>Limits or exclusions</td> <td>\$60</td> </tr> <tr> <td>The total Peg would pay is</td> <td>\$2,260</td> </tr> </tbody> </table> | | Cost Sharing | | Deductibles | \$0 | Copayments | \$2,200 | Coinsurance | \$0 | What isn't covered | | Limits or exclusions | \$60 | The total Peg would pay is | \$2,260 | <p>In this example, Joe would pay:</p> <table border="1"> <thead> <tr> <th colspan="2">Cost Sharing</th> </tr> </thead> <tbody> <tr> <td>Deductibles</td> <td>\$0</td> </tr> <tr> <td>Copayments</td> <td>\$1,100</td> </tr> <tr> <td>Coinsurance</td> <td>\$0</td> </tr> <tr> <th colspan="2">What isn't covered</th> </tr> <tr> <td>Limits or exclusions</td> <td>\$40</td> </tr> <tr> <td>The total Joe would pay is</td> <td>\$1,140</td> </tr> </tbody> </table> | | Cost Sharing | | Deductibles | \$0 | Copayments | \$1,100 | Coinsurance | \$0 | What isn't covered | | Limits or exclusions | \$40 | The total Joe would pay is | \$1,140 | <p>In this example, Mia would pay:</p> <table border="1"> <thead> <tr> <th colspan="2">Cost Sharing</th> </tr> </thead> <tbody> <tr> <td>Deductibles</td> <td>\$0</td> </tr> <tr> <td>Copayments</td> <td>\$1,100</td> </tr> <tr> <td>Coinsurance</td> <td>\$0</td> </tr> <tr> <th colspan="2">What isn't covered</th> </tr> <tr> <td>Limits or exclusions</td> <td>\$0</td> </tr> <tr> <td>The total Mia would pay is</td> <td>\$1,100</td> </tr> </tbody> </table> | | Cost Sharing | | Deductibles | \$0 | Copayments | \$1,100 | Coinsurance | \$0 | What isn't covered | | Limits or exclusions | \$0 | The total Mia would pay is | \$1,100 |
| Cost Sharing | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Deductibles | \$0 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Copayments | \$2,200 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Coinsurance | \$0 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| What isn't covered | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Limits or exclusions | \$60 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| The total Peg would pay is | \$2,260 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cost Sharing | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Deductibles | \$0 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Copayments | \$1,100 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Coinsurance | \$0 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| What isn't covered | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Limits or exclusions | \$40 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| The total Joe would pay is | \$1,140 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cost Sharing | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Deductibles | \$0 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Copayments | \$1,100 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Coinsurance | \$0 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| What isn't covered | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Limits or exclusions | \$0 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| The total Mia would pay is | \$1,100 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: coupehealth.com.

Notice of Nondiscrimination and Accessibility

At Coupe Health, 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 1-833-749-1969 (TTY:711).

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 with our Civil Rights Coordinator.

Nondiscrimination complaint forms and assistance with completing the form are available by calling 1-833-749-1969 (TTY:711) or emailing HealthValet@coupehealth.com.

Email the completed form to Civil.Rights.Coord@CoupeHealth.Com or send it by mail to:

Coupe Health
Attn: Civil Rights Coordinator
12712 Park Central Drive, Suite 100
Dallas, TX 75251

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.

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 1-833-749-1969 (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 1-833-749-1969 (TTY 711).

العربية (Arabic)

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 1-855-1-833-749-1969 (الهاتف النصي 711).

አማርኛ (Amharic)

ትኩረት ይሰጥ፡- አማርኛ ቋንቋ የሚናገሩ ከሆነ፣ ነጻ የቋንቋ እገዛ እገልግሎቶችን 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 ከፍተኛ ማቅረብን ይጨምራል። 1-833-749-1969 (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 1-833-749-1969 (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 1-833-749-1969 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，我们可以用最合适您的方式与您交流。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 1-833-749-1969 (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 kamaa 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 1-833-749-1969 (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 1-833-749-1969 (ATS 711).

ខ្មែរ (Khmer)

ការជូនដំណឹង: ប្រសិនបើ អ្នកនិយាយភាសា ខ្មែរ អ្នកអាចស្នើសុំសេវាជំនួយ បកប្រែភាសាដោយឥតគិតថ្លៃ។ ប្រសិនបើ អ្នកមើលមិនឃើញ ស្តាប់មិនឮ ឬនិយាយមិនបាន យើងអាចប្រាស្រ័យទាក់ទងជាមួយអ្នកតាមរបៀបផ្សេង ដែលមានប្រសិទ្ធភាពល្អបំផុតសម្រាប់អ្នក។ ការប្រាស្រ័យទាក់ទងនេះអាច មានដូចជា អ្នកបកប្រែភាសាសញ្ញា ការផ្តល់ឯកសារដែលបោះពុម្ពអក្សរធំ ឬ អក្សរស្នាប ឬការថតទុកជាសំឡេង ឬជំនួយផ្សេងទៀត ដោយឥតគិតថ្លៃ។ ទូរស័ព្ទទៅលេខ 1-833-749-1969 (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. 1-833-749-1969 (TTY 711) 번으로 전화하십시오.

ကညီကျိာ် (Karen)

ဟ်သ့ဟ်သး- နမ့ၢ်ကတိၤ ကညီကျိာ် န့ၣ်, နယုကျိာ်ဂ့ၢ်ဝိတၢ်တိၤစၢၤမၤစၢၤလၢတလၢာ်ဘူးလဲၤ သ့န့ၣ်လီၤ- နမ့ၢ်အိၣ်ဒီးတၢ်တလၢတပုၤလၢ မံာ်တၢ်ထံၣ်, တၢ်န့ၢ်ဟ့ၣ်, မ့တမ့ၢ် တၢ်စံးကတိၤတၢ်န့ၣ် ပဆဲးကျၢဆဲးကျိးတၢ်လၢ ကျဲကဲထီၣ်လိာ်ထီၣ်အဂ့ၢ်ကတၢ်လၢန့ၢ်သ့န့ၣ်လီၤ- တၢ်အံၤ ပာ်ယုာ်ဒီး တၢ်စူးကါ နီၢ်ဒိက့ၢ်ဂီၤကျိာ်အပုၤကျိာ်ထံတၢ်တဖၣ်, တၢ်ဟ့ၣ်လံာ်လဲၤတဖၣ်လၢ အလံာ်ဖျၢၣ်ဖးဒိၣ်, မ့တမ့ၢ် ပုၤမဲာ်ဘျီၣ်အလံာ်, တၢ်ကလုာ်, မ့တမ့ၢ် တၢ်မၤစၢၤဂုၤဂၤတဖၣ် လၢတလၢာ်အဘူးလဲၤန့ၣ်လီၤ- ကိးလိာ်တိၤဆူ 1-833-749-1969 (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 ပုံပိုးပေးခြင်း၊ အသံဖမ်းယူခြင်းများ သို့မဟုတ် အခြားအထောက်အကူများဖြင့် အခမဲ့ပုံပိုးပေးခြင်းတို့ ပါဝင်ပါသည်။ 1-833-749-1969 (TTY 711) သို့ ဖုန်းခေါ်ဆိုပါ။

OROMOO (Oromo)

Xiyyeeffannoon haa kennamu:- Oromo Afaan kan dubbatan yoo ta'e, tajaajiloota gargaarsa afaanii bilisaa gaafachuu ni dandeessu. Rakkoo ilaalu, 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, waraabbiwwan sagalee ykn gargaarsota biroo kaffaltii tokkoo malee gaafachuu dha. 1-833-749-1969 (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 1-833-749-1969 (TTY 711).

ພາສາລາວ (Lao)

ເຂົາໃຈໃສ່: ຖ້າທ່ານເວົ້າ ພາສາລາວ, ທ່ານສາມາດຂໍບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໄດ້ໂດຍບໍ່ເສຍຄ່າ. ຖ້າທ່ານມີຄວາມບໍາລຸງຮ້າງດ້ານສາຍຕາ, ການໄດ້ຍິນ ຫຼື ການປາກເວົ້າ, ພວກເຂົາສາມາດສືບສານດ້ວຍວິທີທີ່ເໝາະສົມກັບທ່ານທີ່ສຸດ. ອັນນີ້ອາດຈະລວມເຖິງການໃຊ້ນາຍພາສາມື, ການຈັດກຽມເສັ້ນສານເປັນໂຕພິມໃຫຍ່ ຫຼື ອັກສອນນູນ, ການບັນທຶກສຽງ ຫຼື ການຊ່ວຍເຫຼືອດ້ານສື່ອື່ນໆໂດຍບໍ່ເສຍຄ່າໃດໆ. ໃຫ້ 1-833-749-1969 (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 1-833-749-1969 (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 1-833-749-1969 (TTY 711).