

# COUPE HEALTH

## Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

### Bethel University

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

Coverage For: Individual + Family Plan Type: HDHP



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 Valets at 1-833-749-1969 or visit us at [coupehealth.com](http://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](http://www.cciio.cms.gov) or call 1-833-749-1969 to request a copy.

Important Questions	Answers		Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>Tier 1-4 In-Network</b> Employee \$3,300 Family \$6,600		Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	<b>Tier 1-4 In-Network</b> Yes. Preventive services are covered before you meet your deductible		A <a href="#">copayment</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.		You don't have to meet <a href="#">deductible</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>Tier 1-3 In-Network</b> Employee \$5,000 Family \$10,000	<b>Tier 4 Out-of-Network</b> Unlimited	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limit</a> until the overall family <a href="#">out-of-pocket limit</a> has been met. The out-of-pocket for Tier 1, 2 and 3 cross apply.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance billed</a> charges, health care this <a href="#">plan</a> 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 <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://coupehealth.com">coupehealth.com</a> or call 1-833-749-1969 for a list of <a href="#">network providers</a> .		This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's</a> network. You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.		You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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 In-Network	Tier 2 In-Network	Tier 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 <a href="#">copay</a>	\$25 <a href="#">copay</a>	\$40 <a href="#">copay</a>	\$50 <a href="#">copay</a>	Precertification is required for some <a href="#">provider</a> administered drugs; if no precertification is obtained, no benefits are available
	<a href="#">Specialist</a> visit	\$35 <a href="#">copay</a>	\$50 <a href="#">copay</a>	\$80 <a href="#">copay</a>	\$95 <a href="#">copay</a>	
	<a href="#">Preventive care/screening/immunization</a>	No Charge				Please call your Coupe Health Valets at 1-833-749-1969. You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$50 <a href="#">copay</a> (diagnostic x-ray and labs) \$10 <a href="#">copay</a> (routine labs)	\$65 <a href="#">copay</a> (diagnostic x-ray and labs) \$15 <a href="#">copay</a> (routine labs)	\$105 <a href="#">copay</a> (diagnostic x-ray and labs) \$30 <a href="#">copay</a> (routine labs)	\$125 <a href="#">copay</a> (diagnostic x-ray and labs) \$35 <a href="#">copay</a> (routine labs)	Fee listed include facility and <a href="#">physician</a> charges; precertification may be required for some services; if no precertification is obtained, no benefits are available
	Imaging (CT/PET scans, MRIs)	\$165 <a href="#">copay</a>	\$215 <a href="#">copay</a>	\$365 <a href="#">copay</a>	\$435 <a href="#">copay</a>	Precertification is required for advanced imaging; if no precertification is obtained, no benefits are available

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [Coupehealth.com](#) Page 2 of 6

Common Medical Event	Services You May Need	Tier 1 In-Network	Tier 2 In-Network	Tier 3 In-Network	Tier 4 Out-of-Network	Limitations, Exceptions, & Other Important Information
<b>If you need drugs to treat your illness or condition</b>  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://coupehealth.com">coupehealth.com</a>	Preferred Generic Drugs (Tier 1)	\$8 <a href="#">copay</a> (retail) \$16 <a href="#">copay</a> (mail order) \$16 <a href="#">copay</a> (90 day Rx retail)			Not Covered	Prior authorization required for specific drugs; if no precertification is obtained, no benefits are available; benefits listed are for a 30-day supply at retail and 90-day supply at mail; 31-90 day supply of maintenance medication is allowed at retail; specialty drugs are only available for a 30-day supply from a participating specialty drug network supplier
	Non-Preferred Generic Drugs	\$60 <a href="#">copay</a> (retail) \$120 <a href="#">copay</a> (mail order) \$120 <a href="#">copay</a> (90 day Rx retail)			Not Covered	
	Preferred Brand Drugs (Tier 2)	\$30 <a href="#">copay</a> (retail) \$60 <a href="#">copay</a> (mail order) \$60 <a href="#">copay</a> (90 day Rx retail)			Not Covered	
	Non-Preferred Brand Drugs	\$60 <a href="#">copay</a> (retail) \$120 <a href="#">copay</a> (mail order) \$120 <a href="#">copay</a> (90 day Rx retail)			Not Covered	
	Specialty Drugs	\$150 <a href="#">copay</a>			Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$535 <a href="#">copay</a>	\$715 <a href="#">copay</a>	\$1,205 <a href="#">copay</a>	\$1,445 <a href="#">copay</a>	Facility fee listed includes facility and <a href="#">physician</a> charges associated with outpatient facility and surgical services; precertification may be required for some services; if no precertification is obtained, no benefits are available
	Physician/surgeon fees	No Charge				None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$305 <a href="#">copay</a>				Facility fee listed includes facility and physician charges associated with medical emergency services; services apply to tier 1-3 of the <a href="#">out-of-pocket limit</a>
	<a href="#">Emergency medical transportation</a>	\$305 <a href="#">copay</a>				Services apply to tier 1-3 of the <a href="#">out-of-pocket limit</a>
	<a href="#">Urgent care</a>	\$35 <a href="#">copay</a>				None

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [Coupehealth.com](http://Coupehealth.com) **Page 3 of 6**

Common Medical Event	Services You May Need	Tier 1 In-Network	Tier 2 In-Network	Tier 3 In-Network	Tier 4 Out-of-Network	Limitations, Exceptions, & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	\$1,640 <a href="#">copay</a>	\$2,180 <a href="#">copay</a>	\$3,690 <a href="#">copay</a>	\$4,425 <a href="#">copay</a>	Facility fee listed includes facility and <a href="#">physician</a> charges associated with inpatient services; precertification is required; if no precertification is obtained, no benefits are available
	Physician/surgeon fees	No Charge				None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <a href="#">copay</a>	\$25 <a href="#">copay</a>	\$40 <a href="#">copay</a>	\$50 <a href="#">copay</a>	Facility fee listed for inpatient services includes facility and physician services; precertification is required for intensive outpatient, partial <a href="#">hospitalization</a> and inpatient <a href="#">hospitalization</a> ; if no precertification is obtained, no benefit is available
	Inpatient services	\$1,640 <a href="#">copay</a>	\$2,180 <a href="#">copay</a>	\$3,690 <a href="#">copay</a>	\$4,425 <a href="#">copay</a>	
If you are pregnant	Office visits	\$20 <a href="#">copay</a> (initial visit)	\$25 <a href="#">copay</a> (initial visit)	\$40 <a href="#">copay</a> (initial visit)	\$50 <a href="#">copay</a> (initial visit)	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); facility fee listed includes facility and <a href="#">physician services</a> associated with maternity facility services; precertification may be required for some inpatient services; if no precertification is obtained, no benefits are available
	Childbirth/delivery professional services	No Charge				
	Childbirth/delivery facility services	\$1,640 <a href="#">copay</a>	\$2,180 <a href="#">copay</a>	\$3,690 <a href="#">copay</a>	\$4,425 <a href="#">copay</a>	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [Coupehealth.com](#) **Page 4 of 6**

Common Medical Event	Services You May Need	Tier 1 In-Network	Tier 2 In-Network	Tier 3 In-Network	Tier 4 Out-of-Network	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	\$35 <a href="#">copay</a>	\$50 <a href="#">copay</a>	\$80 <a href="#">copay</a>	\$95 <a href="#">copay</a>	Precertification may be required; if no precertification is obtained, no benefits are available; limited to 120 days per member per calendar year; benefits are also available for home infusion services
	<a href="#">Rehabilitation services</a>	\$35 <a href="#">copay</a>	\$50 <a href="#">copay</a>	\$80 <a href="#">copay</a>	\$95 <a href="#">copay</a>	Benefits listed are for <a href="#">Rehabilitation</a> & <a href="#">Habilitation</a> services; each service has a maximum of 20 visits per therapy for occupational, physical and speech therapy per year
	<a href="#">Habilitation services</a>	\$35 <a href="#">copay</a>	\$50 <a href="#">copay</a>	\$80 <a href="#">copay</a>	\$95 <a href="#">copay</a>	
	<a href="#">Skilled nursing care</a>	\$1,445 <a href="#">copay</a>	\$1,920 <a href="#">copay</a>	\$3,250 <a href="#">copay</a>	\$3,900 <a href="#">copay</a>	Limited to 120 days per member per calendar year; precertification is required; if no precertification is obtained, no benefits are available
	<a href="#">Durable medical equipment</a>	\$75 <a href="#">copay</a>	\$100 <a href="#">copay</a>	\$170 <a href="#">copay</a>	\$205 <a href="#">copay</a>	Wigs limited to one per member per calendar year for services related to Alopecia; precertification may be required; if no precertification is obtained, no benefits are available
	<a href="#">Hospice services</a>	\$180 <a href="#">copay</a>	\$240 <a href="#">copay</a>	\$405 <a href="#">copay</a>	\$485 <a href="#">copay</a>	Precertification may be required; if no precertification is obtained, no benefits are available
If your child needs dental or eye care	Children's eye exam	No Charge				Please call your Coupe Health Valets at 1-833-749-1969
	Children's glasses	Not covered				Not covered; member pays 100%
	Children's dental check-up	No Charge				Please call your Coupe Health Valets at 1-833-749-1969

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [Coupehealth.com](#) **Page 5 of 6**

## 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    | • Long-term care       | • Routine foot care |
| • Dental care (Adult) | • Weight Loss Programs | • Bariatric surgery |

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- |   |  |  |
|---|--|--|
| • Acupuncture (limited to medical policy diagnosis categories only)   | • Non-emergency care when traveling outside the U.S.         | • Hearing Aids (limited to one per ear per three calendar years) |
| • Infertility Treatment (including Assisted Reproductive Technology) (\$8,000 medical benefits per lifetime; \$3,500 pharmacy per lifetime) | • Chiropractic care (20 visits per member per calendar year) | • 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](http://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)	
■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,300	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,300	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,300
■ <a href="#">Specialist copayment</a>	\$35	■ <a href="#">Specialist copayment</a>	\$35	■ <a href="#">Specialist copayment</a>	\$35
■ Hospital (facility) <a href="#">copayment</a>	\$1,640	■ Hospital (facility) <a href="#">copayment</a>	\$1,640	■ Hospital (facility) <a href="#">copayment</a>	\$1,640
■ Other <a href="#">copayment</a>	\$305	■ Other <a href="#">copayment</a>	\$305	■ Other <a href="#">copayment</a>	\$305
<p>This EXAMPLE event includes services like:</p> <p><a href="#">Specialist</a> office visits (<i>prenatal care</i>)</p> <p>Childbirth/Delivery Professional Services</p> <p>Childbirth/Delivery Facility Services</p> <p><a href="#">Diagnostic tests</a> (<i>ultrasounds and blood work</i>)</p> <p><a href="#">Specialist</a> visit (<i>anesthesia</i>)</p>		<p>This EXAMPLE event includes services like:</p> <p><a href="#">Primary care physician</a> office visits (<i>including disease education</i>)</p> <p><a href="#">Diagnostic tests</a> (<i>blood work</i>)</p> <p><a href="#">Prescription drugs</a></p> <p><a href="#">Durable medical equipment</a> (<i>glucose meter</i>)</p>		<p>This EXAMPLE event includes services like:</p> <p><a href="#">Emergency room care</a> (<i>including medical supplies</i>)</p> <p><a href="#">Diagnostic tests</a> (<i>x-ray</i>)</p> <p><a href="#">Durable medical equipment</a> (<i>crutches</i>)</p> <p><a href="#">Rehabilitation services</a> (<i>physical therapy</i>)</p>	
<b>Total Example Cost</b>	<b>\$12,700</b>	<b>Total Example Cost</b>	<b>\$5,600</b>	<b>Total Example Cost</b>	<b>\$2,800</b>
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$3,300	<a href="#">Deductibles</a>	\$3,300	<a href="#">Deductibles</a>	\$2,800
<a href="#">Copayments</a>	\$1,700	<a href="#">Copayments</a>	\$200	<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0	<a href="#">Coinsurance</a>	\$0	<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$40	Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$5,060</b>	<b>The total Joe would pay is</b>	<b>\$3,540</b>	<b>The total Mia would pay is</b>	<b>\$2,800</b>

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](#).

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

## 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 لفظية، 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 1-833-749-1969 (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። 1-833-749-1969 (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 1-833-749-1969（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 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 1-833-749-1969 (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៖ ប្រសិនបើអ្នកនិយាយភាសា ខ្មែរ អ្នកអាចស្នើសុំសេវាជំនួយបកប្រែភាសាដោយឥតគិតថ្លៃ។ ប្រសិនបើអ្នកមើលមិនឃើញ ស្តាប់មិនឮ ឬនិយាយមិនបាន យើងអាចប្រាស្រ័យទាក់ទងជាមួយអ្នកតាមរបៀបផ្សេងដែលមានប្រសិទ្ធភាពល្អបំផុតសម្រាប់អ្នក។ ការប្រាស្រ័យទាក់ទងនេះអាចមានដូចជាអ្នកបកប្រែភាសាសញ្ញា ការផ្តល់ឯកសារដែលបោះពុម្ពអក្សរធំៗ ឬអក្សរស្តាប ឬការថតទុកជាសំឡេង ឬជំនួយផ្សេងទៀត ដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 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.

## ကညီကျိန် (Karen)

ဟ်သုဉ်ဟ်သး- နမ္မိကတိၤ ကညီကျိန် န့ၣ်,  
နယုကျိန်ဂီၤတိၤတိၤတိၤတိၤတိၤတိၤတိၤတိၤတိၤ  
နမ္မိအိၣ်ဒီးတိၤတိၤတိၤတိၤတိၤတိၤတိၤတိၤတိၤ  
တိၤစံးကတိၤတိၤန့ၣ် ပဆဲးကျါဆဲးကျိးတိၤလၢ  
ကျဲကဲထီၣ်လိာ်ထီၣ်အဂ့ၤကတိၤလၢနီၣ်သ့န့ၣ်လီၤ  
ပဉ်ယုဒီး တိၤစူးကါ နီၣ်ခိက့ၢ်ဂီၤကျိန်အပုၤကျိန်ထံတိၤတဖၣ်,  
တိၤဟ့ၣ်လံာ်လံာ်တဖၣ်လၢ အလံာ်ဖျါၣ်ဖးဒိၣ်, မ့တမ့ၢ်  
ပုၤမဲာ်ဘျီၣ်အလံာ်, တိၤကလုာ်, မ့တမ့ၢ် တိၤမၤစၢၤဂုၤတဖၣ်  
လၢတလၢာ်အဘူးလဲန့ၣ်လီၤ ကိးလီၤတဲစိဆူ  
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 ပံ့ပိုးပေးခြင်း၊  
အသံဖမ်းယူခြင်းများ သို့မဟုတ်  
အခြားအထောက်အကူများဖြင့် အခမဲ့ပံ့ပိုးပေးခြင်းတို့  
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 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 bireeyyii, waraabbiiwwan 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)

ເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າ ພາສາລາວ,  
ທ່ານສາມາດຂໍບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໄດ້ໂດຍບໍ່ເສຍຄ່າ.  
ຖ້າທ່ານມີຄວາມບໍ່ສະດວກດ້ານສາຍຕາ, ການໄດ້ຍິນ ຫຼື  
ການປາກເວົ້າ,  
ພວກເຮົາສາມາດສະໜອງບໍລິການທີ່ເໝາະສົມກັບທ່ານທີ່ສຸດ.  
ອັນນີ້ອາດຈະລວມເຖິງການໃຊ້ພາສາພາສາມື,  
ການຈັດກຽມເອກະສານເປັນໂຕເພີ່ມໃຫຍ່ ຫຼື ອັກສອນນູນ,  
ການບັນທຶກສຽງ ຫຼື  
ການຊ່ວຍເຫຼືອດ້ານສື່ອື່ນໆໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍໃດໆ. ໂທ  
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).