

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

BCBS of MN - Coupe Health

Coverage Period: 01/01/2026 – 12/31/2026

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 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 ?	Tier 1-3 In-Network \$0	Tier 4 Out-of-Network \$0	There is no overall deductible for this plan.
Are there services covered before you meet your deductible ?	Tier 1-3 In-Network Yes. There is no overall calendar year deductible	Tier 4 Out-of-Network Yes. There is no overall calendar year deductible	There is no overall deductible for this plan. But a copayment or coinsurance 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 deductible for specific services.
What is the out-of-pocket limit for this plan ?	Tier 1-3 In-Network Employee \$2,000 Family \$4,000	Tier 4 Out-of-Network Unlimited	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. The out-of-pocket limit for Tier 1, 2 and 3 cross apply.
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. 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 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 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	\$15 copay	\$25 copay	\$40 copay	Not Covered	Doctor on Demand \$0 copay ; precertification is required for some provider administered drugs; if no precertification is obtained, no benefits are available
	Specialist visit	\$35 copay	\$45 copay	\$75 copay	Not Covered	
	Preventive care/screening/immunization	No Charge			Not Covered	Please visit call your Coupe Health Valet at 1-833-749-1969. 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)	\$50 copay (diagnostic lab and x-ray)	\$65 copay (diagnostic lab and x-ray)	\$110 copay (diagnostic lab and x-ray)	Not Covered	Fee listed include facility and physician charges; precertification may be required for some services; if no precertification is obtained, no benefits are available; routine labs covered tier 1 \$10, tier 2 \$15 and tier 3 \$25 no overall deductible
	Imaging (CT/PET scans, MRIs)	\$170 copay	\$230 copay	\$380 copay	Not Covered	Precertification is required for advanced imaging; if no precertification is obtained, no benefits are available
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at coupehealth.com	Tier 1 (Preferred Generic)	\$5 copay (retail) \$15 copay (mail order)			Not Covered	Precertification 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 with a copay per 30-day supply; specialty drugs are only available for a 30-day supply from a participating specialty drug network supplier
	Tier 2 (Non-Preferred Generic)	\$25 copay (retail) \$75 copay (mail order)			Not Covered	
	Tier 3 (Preferred Brand)	\$15 copay (retail) \$45 copay (mail order)			Not Covered	
	Tier 4 (Non-Preferred Brand)	\$25 copay (retail) \$75 copay (mail order)			Not Covered	

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
	Tier 5 (Specialty Drugs)	\$30 copay (mail order)			Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$550 copay	\$740 copay	\$1,235 copay	Not Covered	Facility fee listed includes facility and physician charges associated with outpatient facility and surgical services; precertification may be required; if no precertification is obtained, no benefits are available
	Physician/surgeon fees	No Charge			Not Covered	None
If you need immediate medical attention	Emergency room care	\$325 copay	\$325 copay	\$325 copay	\$325 copay	Facility fee listed includes facility and physician charges associated with medical emergency services; services apply to tier 1-3 of the out-of-pocket limit
	Emergency medical transportation	\$325 copay	\$325 copay	\$325 copay	\$325 copay	Services apply to tier 1-3 of the out-of-pocket limit
	Urgent care	\$45 copay	\$45 copay	\$45 copay	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$1,035 copay	\$1,380 copay	\$2,000 copay	Not Covered	Facility fee listed includes facility and physician charges associated with inpatient services; precertification is required; if no precertification is obtained, no benefits are available
	Physician/surgeon fees	No Charge			Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 copay	\$25 copay	\$40 copay	Not Covered	Benefits listed for outpatient are physician office visit services; additional benefits are available; facility fee listed for inpatient services includes facility and physician; precertification is required for intensive outpatient, partial hospitalization and inpatient hospitalization ; if no precertification is obtained, no benefits are available
	Inpatient services	\$1,035 copay	\$1,380 copay	\$2,000 copay	Not Covered	

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 are pregnant	Office visits	No Charge			Not Covered	Cost sharing does not apply for preventive services . Depending on the type of services, a copayment , coinsurance or deductible may apply. 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; precertification is required for some inpatient services; if no precertification is obtained, no benefits are available; post-delivery, a newborn does not generate a separate copay if it is a well-baby stay. If it is a NICU or a sick newborn stay, there will be a separate inpatient copay and the date of service is generally the start date in the NICU.
	Childbirth/delivery professional services	No Charge			Not Covered	
	Childbirth/delivery facility services	\$1,035 copay	\$1,380 copay	\$2,000 copay	Not Covered	
	Home health care	\$35 copay	\$45 copay	\$75 copay	Not Covered	Precertification may be required; if no precertification is obtained, no benefits are available; benefits are also available for home infusion services
	Rehabilitation services	\$35 copay	\$45 copay	\$75 copay	Not Covered	None
	Habilitation services	\$35 copay	\$45 copay	\$75 copay	Not Covered	
	Skilled nursing care	\$930 copay	\$1,240 copay	\$2,000 copay	Not Covered	Limited to 120 days per member per calendar year; precertification is required; if no precertification is obtained, no benefits are available
	Durable medical equipment	\$75 copay	\$100 copay	\$170 copay	Not Covered	Precertification may be required; if no precertification is obtained, no benefits are available
	Hospice services	\$185 copay	\$245 copay	\$410 copay	Not Covered	Precertification may be required; if no precertification is obtained, no benefits are available

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 your child needs dental or eye care	Children's eye exam	No Charge			Not covered	Please call your Coupe Health Valet at 1-833-749-1969
	Children's glasses	Not Covered				Not covered; member pays 100%
	Children's dental check-up	Not Covered				Please call your Coupe Health Valet at 1-833-749-1969

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 .)		
<ul style="list-style-type: none">• Cosmetic surgery• Dental care (Adult)	<ul style="list-style-type: none">• Long-term care• Weight Loss Programs	<ul style="list-style-type: none">• Routine foot care• Private-duty nursing
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none">• Acupuncture (limited to a maximum of 20 visits per member per calendar year for medical policy diagnosis categories only)• Bariatric surgery• Chiropractic care	<ul style="list-style-type: none">• Infertility Treatment (limited to a combined medical and prescription drug lifetime maximum of \$25,000)• Non-emergency care when traveling outside the U.S.	<ul style="list-style-type: none">• Hearing Aids (limitations apply)• 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)	
■ The plan's overall deductible	\$0	■ The plan's overall deductible	\$0	■ The plan's overall deductible	\$0
■ Specialist copayment	\$35	■ Specialist copayment	\$35	■ Specialist copayment	\$35
■ Hospital (facility) copayment	\$1,035	■ Hospital (facility) copayment	\$1,035	■ Hospital (facility) copayment	\$1,035
■ Other copayment	\$325	■ Other copayment	\$325	■ Other copayment	\$325
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>)		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>)		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>)	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
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>	
Deductibles	\$0	Deductibles	\$0	Deductibles	\$0
Copayments	\$1,600	Copayments	\$700	Copayments	\$1,300
Coinsurance	\$0	Coinsurance	\$0	Coinsurance	\$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
The total Peg would pay is	\$1,660	The total Joe would pay is	\$740	The total Mia would pay is	\$1,300

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.

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 P3-2
PO Box 64560
Eagan, MN 55164-0560

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

Visit coupehealth.com and log in to your member portal to view an electronic version of this notice.

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 ឬអក្សរស្លាប 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- နမ္မာကတိၤ ကညီကျိန် န့ၣ်,
နယုကျိန်ဂီၤတိၤတိၤမၤစၢၤလၢတလၢ်ဘူးလဲ သ့န့ၣ်လီၤ
နမ္မာအိၣ်ဒီးတၢ်တလၢတပွဲၤလၢ မဲၢ်တၢ်ထံၣ်, တၢ်နီၤဟူ, မ့တမ့ၢ်
တၢ်စံးကတိၤတၢ်န့ၣ် ပဆဲးကျၢဆဲးကျိးတၢ်လၢ
ကျဲကဲထီၣ်လိာ်ထီၣ်အဂ့ၤကတၢ်လၢနီၤသ့န့ၣ်လီၤ တၢ်အံၤ
ပၣ်ယုဒီး တၢ်စူးကါ နီၤခိက့ၢ်ဂီၤကျိန်အပူၤကျိန်ထံတၢ်တဖၣ်,
တၢ်ဟ့ၣ်လံာ်လံာ်တဖၣ်လၢ အလံာ်ဖျၢၣ်ဖးဒိၣ်, မ့တမ့ၢ်
ပှၤမဲၢ်ဘျီၣ်အလံာ်, တၢ်ကလုာ်, မ့တမ့ၢ် တၢ်မၤစၢၤလၢတဖၣ်
လၢတလၢ်အဘူးလဲန့ၣ်လီၤ 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,
ພວກເຮົາສາມາດສ້າງສານດ້ວຍວິທີທີ່ເໝາະສົມກັບທ່ານທີ່ສຸດ.
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).