

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

Fabcon Companies HDHP Plan Coupe Health

Coverage Period: 07/01/2026 – 06/30/2027

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 Valet at 1-833-749-1969 or visit us at member.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 \$2,000 / individual or \$4,000 family in-network	Tier 4 Out-of-Network \$5,500 / individual or \$11,000 / family out-of-network	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible ?	Tier 1-3 In-Network Yes	Tier 4 Out-of-Network Yes	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 ?	Tier 1-3 In-Network \$4,500 / individual \$9,000 / family	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 on this plan , the overall family out-of-pocket limit must be 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 member.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	\$15 copay	\$25 copay	\$60 copay	\$75 copay	Precertification may be required for some provider administered drugs; if no precertification is obtained, no benefits are available; Doctor on Demand Behavioral Health and Urgent Care at no charge for tiers 1-3, Doctor on Demand Virtual Primary Care – Medical Services with a \$15 per visit for tiers 1-3.
	Specialist visit	\$30 copay	\$40 copay	\$90 copay	\$130 copay	
	Preventive care/screening/immunization	No Charge				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)	Advanced Labs: \$60 copay Diagnostic Radiology: \$50 copay Basic Labs: \$15 copay	Advanced Labs: \$80 copay Diagnostic Radiology: \$75 copay Basic Labs: \$20 copay	Advanced Labs: \$140 copay Diagnostic Radiology: \$130 copay Basic Labs: \$40 copay	Advanced Labs: \$170 copay Diagnostic Radiology: \$170 copay Basic Labs: \$60 copay	Fees listed include facility and physician charges; precertification may be required; if no precertification is obtained, no benefits are available.
	Imaging (CT/PET scans, MRIs)	\$175 copay	\$250 copay	\$400 copay	\$560 copay	

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 please refer to your prescription drug Pharmacy Benefit Manager, member.coupehealth.com	Tier 1 (Preferred Generic)	\$10 copay (retail) \$20 copay (mail order) \$20 copay (90-day Rx retail)			Not Covered	Precertification may be required for some drugs; if precertification is not obtained, no benefits are available. Retail and specialty drugs are limited to a 31-day supply.
	Tier 2 (Non-Preferred Generic)	\$45 copay (retail) \$90 copay (mail order) \$90 copay (90-day Rx retail)			Not Covered	
	Tier 3 (Preferred Brand)	\$45 copay (retail) \$90 copay (mail order) \$90 copay (90-day Rx retail)			Not Covered	
	Tier 4 (Non-Preferred Brand)	\$90 copay (retail) \$180 copay (mail order) \$180 copay (90-day Rx retail)			Not Covered	
	Tier 5 (Specialty drugs)	\$200 copay			Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$600 copay	\$900 copay	\$1,500 copay	\$1,850 copay	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				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; copay waived if admitted within 24 hours; services apply to tier 1-3 out-of-pocket maximum.
	Emergency medical transportation	\$250 copay				None
	Urgent care	\$45 copay				None

Common Medical Event	Services You May Need	Tier 1 - 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)	\$1,600 copay	\$2,200 copay	\$3,800 copay	\$6,000 copay	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				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: \$15 copay Outpatient: \$600 copay	Physician's Office: \$25 copay Outpatient: \$900 copay	Physician's Office: \$60 copay Outpatient: \$1,500 copay	Physician's Office: \$75 copay Outpatient: \$1,850 copay	Facility fee listed for inpatient services includes facility and physician; precertification may be required; if no precertification is obtained, no benefits are available.
	Inpatient services	\$1,600 copay	\$2,200 copay	\$3,800 copay	\$6,000 copay	
If you are pregnant	Office visits	Initial Visit: \$15 copay Prenatal Visit: No Charge	Initial Visit: \$25 copay Prenatal Visit: No Charge	Initial Visit: \$60 copay Prenatal Visit: No Charge	Initial Visit: \$75 copay Prenatal Visit: No Charge	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				
	Childbirth/delivery facility services	\$1,600 copay	\$2,200 copay	\$3,800 copay	\$6,000 copay	

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	\$30 copay	\$60 copay	\$100 copay	\$140 copay	Precertification may be required; if no precertification is obtained, no benefits are available; benefits are also available for home infusion services.
	Rehabilitation services	\$30 copay	\$60 copay	\$100 copay	\$140 copay	Limited to 120 visits combined per member per benefit period for occupational, physical and speech therapy; behavioral health does not apply to limits.
	Habilitation services	\$30 copay	\$60 copay	\$100 copay	\$140 copay	
	Skilled nursing care	\$1,350 copay	\$1,800 copay	\$3,100 copay	\$5,000 copay	Limited to 120 days per benefit period across all providers and networks; precertification may be required; if no precertification is obtained, no benefits are available.
	Durable medical equipment	\$65 copay	\$90 copay	\$150 copay	\$275 copay	Precertification may be required; if no precertification is obtained, no benefits are available; benefits are provided for wigs for Alopecia and cancer and limited to one per member per benefit period; Cochlear Implants covered
	Hospice services	\$290 copay	\$390 copay	\$650 copay	\$780 copay	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 Valet at 1-833-749-1969
	Children's glasses	Not Covered				Not covered; member pays 100%
	Children's dental check-up	Not Covered				Not covered; member pays 100%

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)
- Fertility Treatment
- Long-term care
- Private-duty nursing

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

- Acupuncture (limited to 15 visits per member per benefit period)
- Bariatric Surgery (limitations apply)
- Chiropractic care
- Hearing Aids (limitations apply)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care (limitations apply)
- Weight Loss Programs (limitations apply)

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)

■ The plan's overall deductible	\$2,000
■ Specialist copayment	\$30
■ Hospital (facility) copayment	\$1,600
■ Other copayment	\$250

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$2,000
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$4,060

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$2,000
■ Specialist copayment	\$30
■ Hospital (facility) copayment	\$1,600
■ Other copayment	\$250

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$500
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$40
The total Joe would pay is	\$2,540

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$2,000
■ Specialist copayment	\$30
■ Hospital (facility) copayment	\$1,600
■ Other copayment	\$250

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic tests](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$300
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,300

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: member.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 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 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,
နယုကျိန်ဂီၢ်တိၤတိၤမၤစၢၤလၢတလၢ်ဘူးလဲ သ့န့ၣ်လီၤ
နမ္မိအိၣ်ဒီးတၢ်တလၢတပွဲၤလၢ မဲၢ်တၢ်ထံၣ်, တၢ်နီၤဟူ, မ့တမ့ၢ်
တၢ်စံးကတိၤတၢ်န့ၣ် ပဆဲးကျၢဆဲးကျိးတၢ်လၢ
ကျဲကဲထီၣ်လိာ်ထီၣ်အဂ့ၢ်ကတၢ်လၢနီၤသ့န့ၣ်လီၤ တၢ်အံၤ
ပၣ်ယုဒီး တၢ်စူးကါ နီၤခိက့ၢ်ဂီၤကျိန်အပူၤကျိန်ထံတၢ်တဖၣ်,
တၢ်ဟ့ၣ်လံာ်လံာ်တဖၣ်လၢ အလံာ်ဖျါၣ်ဖးဒိၣ်, 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,
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).