COUPE HEALTH

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

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

## St. Olaf College Coupe Health

**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 Pro 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 https://www.healthcare.gov/sbc-glossary 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**<br>Employee $3,550<br>Family $7,100 | **Tier 4 Out-of-Network**<br>Employee $3,550<br>Family $7,100 | 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, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | **Tier 1-3 In-Network**<br>Yes. | **Tier 4 Out-of-Network**<br>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 deductible for specific services. |
| **What is the out–of–pocket limit for this plan?** | **Tier 1-3 In-Network**<br>Employee $4,800<br>Family $9,600 | **Tier 4 Out-of-Network**<br>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 maximums for all networks 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 prior authorization 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. 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 | $20 copay | $30 copay | $40 copay | Prior authorization may be required for some provider administered drugs; if prior authorization is not obtained, no benefits are available |
| | Specialist visit | $30 copay | $40 copay | $65 copay | $80 copay | |
| | Preventive care/screening/ immunization | No Charge<br>Deductible does not apply | | | | Please call your Coupe Health Pro at 1-833-749-1969. Additional services are available. 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) | $40 copay | $55 copay | $90 copay | $110 copay | Fee listed include facility and physician charges; prior authorization may be required for some services; if no prior authorization is obtained, no benefits are available. Labs covered at Tier 1 $10, Tier 2 $15, Tier 3 $20, Tier 4 $30 |
| | Imaging (CT/PET scans, MRIs) | $140 copay | $190 copay | $315 copay | $400 copay | Prior authorization is required for advanced imaging; if prior authorization is not 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 you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at member.coupehealth.com | Preferred Generic Drugs (Tier 1) | $5 copay (retail)<br>$15 copay (mail order) | $10 copay (retail)<br>$15 copay (mail order) | $15 copay (retail)<br>$15 copay (mail order) | Not Covered | Prior authorization is required for some drugs; if no prior authorization is obtained, no benefits are available; benefits listed are for a 30-day supply at retail, and 90-day supply at in-network mail order |
| | Preferred Brand Drugs (Tier 2) | $10 copay (retail)<br>$25 copay (mail order) | $15 copay (retail)<br>$25 copay(mail order) | $25 copay (retail)<br>$25 copay(mail order) | Not Covered | |
| | Non-Preferred Brand Drugs | $15 copay (retail)<br>$30 copay (mail order) | $20 copay (retail)<br>$30 copay (mail order) | $30 copay (retail)<br>$30 copay (mail order) | Not Covered | |
| | Specialty Drugs | $10 copay | $10 copay | $10 copay | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $465 copay | $615 copay | $1,030 copay | $1,236 copay | Facility fee listed includes facility and physician charges associated with outpatient facility and surgical services; prior authorization may be required; if prior authorization is not obtained, no benefits are available |
| | Physician/surgeon fees | No Charge<br>Included in facility fee | No Charge<br>Included in facility fee | No Charge<br>Included in facility fee | No Charge<br>Included in facility fee | None |
| **If you need immediate medical attention** | Emergency room care | $265 copay | $265 copay | $265 copay | $265 copay | Facility fee listed includes facility and physician charges associated with medical emergency services; services apply to the tier 1-3 of the out-of-pocket maximum |
| | Emergency medical transportation | $265 copay | $265 copay | $265 copay | $265 copay | Services apply to the tier 1-3 of the out-of-pocket maximum |
| | Urgent care | $30 copay | $40 copay | $65 copay | $80 copay | None |

| 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) | $1,425 copay | $1,900 copay | $3,000 copay | $3,800 copay | Facility fee listed includes facility and physician charges associated with inpatient services; prior authorization is required; if prior authorization is not obtained, no benefits are available |
| | Physician/surgeon fees | No Charge Included in facility fee | No Charge Included in facility fee | No Charge Included in facility fee | No Charge Included in facility fee | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $15 copay | $20 copay | $30 copay | $40 copay | Benefits listed for outpatient are physician office visit services; additional benefits are available; facility fee listed for inpatient services includes facility and physician; prior authorization is required; if prior authorization is not obtained, no benefits are available |
| | Inpatient services | $1,425 copay | $1,900 copay | $3,000 copay | $3,800 copay | |
| **If you are pregnant** | Office visits | No Charge Included in facility fee | No Charge Included in facility fee | No Charge Included in facility fee | No Charge Included in facility fee | 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.<br><br>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. Prior authorization may be required for some inpatient services; if prior authorization is not obtained, no benefits are available |
| | Childbirth/delivery professional services | No Charge Included in facility fee | No Charge Included in facility fee | No Charge Included in facility fee | No Charge Included in facility fee | |
| | Childbirth/delivery facility services | $1,425 copay | $1,900 copay | $3,000 copay | $3,800 copay | |

| 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** | Home health care | $30 copay | $40 copay | $65 copay | $80 copay | Prior authorization is required; if prior authorization is not obtained, no benefits are available; benefits are also available for home infusion services |
| | Rehabilitation services | $30 copay | $40 copay | $65 copay | $78 copay | None |
| | Habilitation services | $30 copay | $40 copay | $65 copay | $78 copay | |
| | Skilled nursing care | $1,255 copay | $1,675 copay | $2,795 copay | $3,400 copay | Prior authorization is required; if prior authorization is not obtained, no benefits are available |
| | Durable medical equipment | $65 copay | $85 copay | $140 copay | $170 copay | Wigs limited to one per member per calendar year for services related to alopecia; prior authorization is required; if prior authorization is not obtained, no benefits are available |
| | Hospice services | $155 copay | $205 copay | $345 copay | $420 copay | Prior authorization is required; if prior authorization is not obtained, no benefits are available |
| **If your child needs dental or eye care** | Children's eye exam | No Charge<br>Deductible does not apply | | | | Please call your Coupe Health Pro at 1-833-749-1969 |
| | Children's glasses | Not covered | | | | Not covered; member pays 100% |
| | Children's dental check-up | No Charge<br>Deductible does not apply | | | | Please call your Coupe Health Pro 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.) | | |
|---|---|---|
| • Cosmetic surgery | • Long-term care | • Routine foot care |
| • Dental care (Adult) | • Weight Loss Programs | • Private-duty nursing |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • Acupuncture | • Infertility Treatment (limitations apply) | • Hearing Aids (limited to children age 18 and younger, additional limitations apply) |
| • Chiropractic care | • Non-emergency care when traveling outside the U.S. | • Routine eye care (Adult) |
| • Bariatric surgery | | |

**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 www.dol.gov/ebsa/healthreform. 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 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 www.dol.gov/ebsa/healthreform.

**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.*

* For more information about limitations and exceptions, see the plan or policy document at coupehealth.com

## 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 | $3,550 |
| Specialist copayment | $30 |
| Hospital (facility) copayment | $1,425 |
| Other copayment | $465 |

**This EXAMPLE event includes services like:**
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

| | |
|---|---|
| **Total Example Cost** | **$12,700** |

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $3,550 |
| Copayments | $1,200 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$4,810** |

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

| | |
|---|---|
| The plan's overall deductible | $3,550 |
| Specialist copayment | $30 |
| Hospital (facility) copayment | $1,425 |
| Other copayment | $465 |

**This EXAMPLE event includes services like:**
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

| | |
|---|---|
| **Total Example Cost** | **$5,600** |

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $3,550 |
| Copayments | $200 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $40 |
| **The total Joe would pay is** | **$3,790** |

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

| | |
|---|---|
| The plan's overall deductible | $3,550 |
| Specialist copayment | $30 |
| Hospital (facility) copayment | $1,425 |
| Other copayment | $465 |

**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** |

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,600 |
| Copayments | $100 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,700** |

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.

**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 1-833-749-1969 (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.

**ကညီကျိာ် (Karen)**
ဟ်သူဉ်ဟ်သး- နမ့်ကတိၤ ကညီကျိာ် နှဉ်,
နဃ့ကျိာ်ဂ့်ဝီတ်ါတိစၢၤမၤစၢၤလၢတလာ်ဘူးလဲ သ့နှဉ်လီၤ.
နမ့်အိဉ်ဒီးတ်ါတလၢတပှဲၤလၢ မဲာ်တ်ါထံဉ်, တ်ါန်ဟူ, မ့တမ့်ါ
တ်ါစံးကတိၤတ်ါနှဉ် ပဆဲးကျၢဆဲးကျိုးတ်ါလၢ
ကျဲကဲထီဉ်လိာ်ထီဉ်အဂ့ၤကတ်ါလၢနဂီၢ်သ့နှဉ်လီၤ. တ်ါအံၤ
ပဉ်ဃာ်ဒီး တ်ါစူးကါ နီၢ်ခိက့ၢ်ဂီၤကျိာ်အပှၤကျိာ်ထံတ်ါတဖဉ်,
တ်ါဟ့ဉ်လံာ်လဲၢ်တဖဉ်လၢ အလံာ်ဖျၢဉ်ဖးဒိဉ်, မ့တမ့်ါ
ပှၤမဲာ်ဘျိဉ်အလံာ်, တ်ါကလုၢ်, မ့တမ့်ါ တ်ါမၤစၢၤဂုၤဂၤတဖဉ်
လၢတလာ်အဘူးလဲနှဉ်လီၤ. ကိးလီတဲစိဆူ
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 မျက်မြင်စာဖြင့် 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 bireeylii, 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.
ຖ້າທ່ານມີຄວາມບົກຜ່ອງດ້ານສາຍຕາ, ການໄດ້ຍິນ ຫຼື
ການປາກເວົ້າ,
ພວກເຮົາສາມາດສື່ສານດ້ວຍວິທີທີ່ເໝາະສົມກັບທ່ານທີ່ສຸດ.
ອັນນີ້ອາດຈະລວມເຖິງການໃຊ້ນາຍພາສາມື,
ການຈັດກຽມເອກະສານເປັນໂຕພິມໃຫຍ່ 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).