



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 1-855-813-3888 or visit us at [www.healthpartners.com](http://www.healthpartners.com). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-855-813-3888 to request a copy.

| Important Questions                                                       | Answers                                                                                                                                                                       | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall <u>deductible</u>?</b>                             | In-network: \$5,500 Individual/\$11,000 Family<br>Out-of-network: \$10,000 Individual/\$20,000 Family                                                                         | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .                                                                                                                                                              |
| <b>Are there services covered before you meet your <u>deductible</u>?</b> | Yes. <u>Coinsurance</u> marked with * under What You Will Pay and benefits with no charge are not subject to <u>deductible</u>                                                | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain preventive services without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                         |
| <b>Are there other <u>deductibles</u> for specific services?</b>          | No.                                                                                                                                                                           | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>       | In-network medical/pharmacy: \$5,750 Individual/\$11,500 Family<br>Out-of-network medical/pharmacy: \$30,000 Individual/\$60,000 Family                                       | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.                                                                                                                                                                                                                                                                                    |
| <b>What is not included in the <u>out-of-pocket limit</u>?</b>            | <u>Premium</u> , balance-billed charges (unless <u>balanced billing</u> is prohibited), and health care this <u>plan</u> doesn't cover.                                       | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Will you pay less if you use a <u>network provider</u>?</b>            | Yes. See <a href="http://www.healthpartners.com/robin/broad">http://www.healthpartners.com/robin/broad</a> or call 1-855-813-3888 for a list of <u>in-network providers</u> . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| <b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>          | No.                                                                                                                                                                           | You can see the in-network <u>specialist</u> you choose without a <u>referral</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |

 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                            | What You Will Pay                                                                                                          |                                                                                                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                    |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                               |                                                  | Network Provider<br>(You will pay the least)                                                                               | Out-of-Network Provider<br>(You will pay the most)                                                                                 |                                                                                                                                                                           |
| <b>If you visit a health care provider's office or clinic</b>                                                                                                                                                                                                 | Primary care visit to treat an injury or illness | Primary Office Visit: 0% <u>coinsurance</u><br>Convenience Care: 0% <u>coinsurance</u><br>virtuwell: 0% <u>coinsurance</u> | Primary Office Visit: 50% <u>coinsurance</u><br>Convenience Care: 50% <u>coinsurance</u>                                           | None                                                                                                                                                                      |
|                                                                                                                                                                                                                                                               | Specialist visit                                 | 0% <u>coinsurance</u>                                                                                                      | 50% <u>coinsurance</u>                                                                                                             | None                                                                                                                                                                      |
|                                                                                                                                                                                                                                                               | Preventive care/screening/immunization           | No charge                                                                                                                  | 50% <u>coinsurance</u>                                                                                                             | You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for. |
| <b>If you have a test</b>                                                                                                                                                                                                                                     | Diagnostic test (x-ray, blood work)              | 0% <u>coinsurance</u>                                                                                                      | 50% <u>coinsurance</u>                                                                                                             | None                                                                                                                                                                      |
|                                                                                                                                                                                                                                                               | Imaging (CT/PET scans, MRIs)                     | 0% <u>coinsurance</u>                                                                                                      | 50% <u>coinsurance</u>                                                                                                             | None                                                                                                                                                                      |
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.healthpartners.com/genericsadvantagerx">www.healthpartners.com/genericsadvantagerx</a> | Generic drugs                                    | Formulary: 0% <u>coinsurance</u><br>Non-formulary: 20% <u>coinsurance</u>                                                  | Formulary: 50% <u>coinsurance</u> at retail, mail not covered<br>Non-formulary: 50% <u>coinsurance</u> at retail, mail not covered | 31 day supply retail/ 93 day supply mail order. Select Preventive Drugs: no charge generic/\$60 brand copay, deductible does not apply.                                   |
|                                                                                                                                                                                                                                                               | Formulary brand drugs                            | 0% <u>coinsurance</u>                                                                                                      | 50% <u>coinsurance</u> at retail, mail not covered                                                                                 |                                                                                                                                                                           |
|                                                                                                                                                                                                                                                               | Non-formulary brand drugs                        | 20% <u>coinsurance</u>                                                                                                     | 50% <u>coinsurance</u> at retail, mail not covered                                                                                 |                                                                                                                                                                           |
|                                                                                                                                                                                                                                                               | Specialty drugs                                  | 0% <u>coinsurance</u>                                                                                                      | Not covered                                                                                                                        | None                                                                                                                                                                      |
| <b>If you have outpatient surgery</b>                                                                                                                                                                                                                         | Facility fee (e.g., ambulatory surgery center)   | 0% <u>coinsurance</u>                                                                                                      | 50% <u>coinsurance</u>                                                                                                             | None                                                                                                                                                                      |
|                                                                                                                                                                                                                                                               | Physician/surgeon fees                           | 0% <u>coinsurance</u>                                                                                                      | 50% <u>coinsurance</u>                                                                                                             | None                                                                                                                                                                      |
| <b>If you need immediate medical attention</b>                                                                                                                                                                                                                | Emergency room care                              | 0% <u>coinsurance</u>                                                                                                      | 0% <u>coinsurance</u>                                                                                                              | Out-of-network services apply to the in-network deductible.                                                                                                               |
|                                                                                                                                                                                                                                                               | Emergency medical transportation                 | 0% <u>coinsurance</u>                                                                                                      | 0% <u>coinsurance</u>                                                                                                              | Out-of-network services apply to the in-network deductible.                                                                                                               |

| Common Medical Event                                                                    | Services You May Need                     | What You Will Pay                            |                                                    | Limitations, Exceptions, & Other Important Information                                 |
|-----------------------------------------------------------------------------------------|-------------------------------------------|----------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------|
|                                                                                         |                                           | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                        |
|                                                                                         | <u>Urgent care</u>                        | 0% <u>coinsurance</u>                        | 0% <u>coinsurance</u>                              | Out-of-network services apply to the in-network deductible.                            |
| <b>If you have a hospital stay</b>                                                      | Facility fee (e.g., hospital room)        | 0% <u>coinsurance</u>                        | 50% <u>coinsurance</u>                             | None                                                                                   |
|                                                                                         | Physician/surgeon fees                    | 0% <u>coinsurance</u>                        | 50% <u>coinsurance</u>                             | None                                                                                   |
| <b>If you need mental health, behavioral health, or substance use disorder services</b> | Outpatient services                       | 0% <u>coinsurance</u>                        | 50% <u>coinsurance</u>                             | None                                                                                   |
|                                                                                         | Inpatient services                        | 0% <u>coinsurance</u>                        | 50% <u>coinsurance</u>                             | None                                                                                   |
| <b>If you are pregnant</b>                                                              | Office visits                             | No charge                                    | 50% <u>coinsurance</u>                             | Depending on the type of services, a copayment, coinsurance, or deductible may apply.  |
|                                                                                         | Childbirth/delivery professional services | 0% <u>coinsurance</u>                        | 50% <u>coinsurance</u>                             | None                                                                                   |
|                                                                                         | Childbirth/delivery facility services     | 0% <u>coinsurance</u>                        | 50% <u>coinsurance</u>                             | None                                                                                   |
| <b>If you need help recovering or have other special health needs</b>                   | <u>Home health care</u>                   | 0% <u>coinsurance</u>                        | 50% <u>coinsurance</u>                             | 60 visit limit in-network, 30 visit limit out-of-network                               |
|                                                                                         | <u>Rehabilitation services</u>            | 0% <u>coinsurance</u>                        | 50% <u>coinsurance</u>                             | 20 visit limit for in and out-of-network for physical, occupational and speech therapy |
|                                                                                         | <u>Habilitation services</u>              | 0% <u>coinsurance</u>                        | 50% <u>coinsurance</u>                             | 20 visit limit for in and out-of-network for physical, occupational and speech therapy |
|                                                                                         | <u>Skilled nursing care</u>               | 0% <u>coinsurance</u>                        | 50% <u>coinsurance</u>                             | Limited to 30 day maximum in-network, 15 day maximum out-of-network                    |
|                                                                                         | <u>Durable medical equipment</u>          | 0% <u>coinsurance</u>                        | 50% <u>coinsurance</u>                             | None                                                                                   |
|                                                                                         | <u>Hospice services</u>                   | 0% <u>coinsurance</u>                        | 50% <u>coinsurance</u>                             | None                                                                                   |
| <b>If your child needs dental or eye care</b>                                           | Children's eye exam                       | No charge                                    | 50% <u>coinsurance</u>                             | None                                                                                   |
|                                                                                         | Children's glasses                        | 0% <u>coinsurance</u>                        | Not covered                                        | Limit of one pair of eyeglasses or contact lenses per year.                            |
|                                                                                         | Children's dental check-up                | No charge                                    | 50% <u>coinsurance</u>                             | None                                                                                   |

## Excluded Services & Other Covered Services:

### **Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- |                                                                                             |                         |                        |
|---------------------------------------------------------------------------------------------|-------------------------|------------------------|
| • Acupuncture                                                                               | • Hearing aids          | • Private-duty nursing |
| • Bariatric surgery                                                                         | • Infertility treatment | • Routine foot care    |
| • Cosmetic surgery with the exception of port wine stain removal and reconstructive surgery | • Long-term care        | • Weight loss programs |
| • Dental care (Adult)                                                                       |                         |                        |

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

- |                     |                                                      |                            |
|---------------------|------------------------------------------------------|----------------------------|
| • Chiropractic care | • Non-emergency care when traveling outside the U.S. | • Routine eye care (Adult) |
|---------------------|------------------------------------------------------|----------------------------|

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Your plan at 1-800-883-2177, or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov), or the Wisconsin Office of the Commissioner of Insurance at 608-266-0103 / 1-800-236-8517. 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 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 at 1-800-883-2177 or the Wisconsin Office of the Commissioner of Insurance at 608-266-0103 / 1-800-236-8517. Additionally, a consumer assistance program can help you file your appeal. Contact the Wisconsin Office of the Commissioner of Insurance at 608-266-0103 / 1-800-236-8517.

**Does this plan provide Minimum Essential Coverage? Yes.**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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.

## **Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-398-9119.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-883-2177.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-883-2177.

Navajo (Dine): Dineek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-883-2177.

*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   | \$5,500 |
| ■ Specialist coinsurance          | 0%      |
| ■ Hospital (facility) coinsurance | 0%      |
| ■ Other coinsurance               | 0%      |

#### 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

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

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$5,500        |
| Copayments                        | \$0            |
| Coinsurance                       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$5,560</b> |

### Managing Joe's type 2 Diabetes

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

|                                   |         |
|-----------------------------------|---------|
| ■ The plan's overall deductible   | \$5,500 |
| ■ Specialist coinsurance          | 0%      |
| ■ Hospital (facility) coinsurance | 0%      |
| ■ Other coinsurance               | 0%      |

#### 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$7,300</b> |
|---------------------------|----------------|

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

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$5,500        |
| Copayments                        | \$0            |
| Coinsurance                       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Joe would pay is</b> | <b>\$5,560</b> |

### Mia's Simple Fracture

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

|                                   |         |
|-----------------------------------|---------|
| ■ The plan's overall deductible   | \$5,500 |
| ■ Specialist coinsurance          | 0%      |
| ■ Hospital (facility) coinsurance | 0%      |
| ■ Other coinsurance               | 0%      |

#### This EXAMPLE event includes services like:

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

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$1,900</b> |
|---------------------------|----------------|

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

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$1,900        |
| Copayments                        | \$0            |
| Coinsurance                       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,900</b> |



# Statement of Nondiscrimination for Health Plan Members

## Our Responsibilities:

We follow Federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability or sex. We do not exclude people or treat them differently because of their race, color, national origin, age, disability or sex, including gender identity.

- We help people with disabilities to communicate with us. This help is free. It includes:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio and accessible electronic formats
- We provide services for people who do not speak English or who are not comfortable speaking English. These services are free. They include:
  - Qualified interpreters
  - Information written in other languages

## For Language or Communication Help:

Call 1-800-883-2177 if you need language or other communication help. (TTY: 711)

## If you have questions about our non-discrimination policy:

Contact the Civil Rights Coordinator at 1-844-363-8732 or [integrityandcompliance@healthpartners.com](mailto:integrityandcompliance@healthpartners.com).

## To File a Grievance:

If you believe that we have not provided these services or have discriminated against you because of your race, color, national origin, age, disability or sex, you can file a grievance by contacting the Civil Rights Coordinator at 1-844-363-8732, [integrityandcompliance@healthpartners.com](mailto:integrityandcompliance@healthpartners.com) or Civil Rights Coordinator, Office of Integrity and Compliance, MS 21103K, 8170 33rd Ave. S., Bloomington, MN 55425.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
Room 509F, HHH Building  
200 Independence Avenue SW, Washington, DC 20201  
1-800-368-1019, 800-537-7697 (TDD)

|                                                                                                                                                                                                        |                                                                                                                                                                                                     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Español (Spanish)</b><br/> <b>ATENCIÓN:</b> si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-883-2177. (TTY: 711)</p>                      | <p><b>ພາສາລາວ (Laotian)</b><br/> <b>ໂປດຊາບ:</b> ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການລ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-883-2177. (TTY: 711)</p>                          |
| <p><b>Hmoob (Hmong)</b><br/> <b>LUS CEEV:</b> Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-883-2177. (TTY: 711)</p>                                      | <p><b>Deutsch (German)</b><br/> <b>ACHTUNG:</b> Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-883-2177. (TTY: 711)</p>        |
| <p><b>Tiếng Việt (Vietnamese)</b><br/> <b>CHÚ Ý:</b> Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-883-2177. (TTY: 711)</p>                               | <p><b>العربية (Arabic)</b><br/> <b>ملحوظة:</b> إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-883-2177 (رقم هاتف الصم والبكم: 711)</p>                     |
| <p><b>繁體中文 (Chinese)</b><br/> <b>注意:</b> 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-883-2177. (TTY: 711)</p>                                                                                                    | <p><b>Français (French)</b><br/> <b>ATTENTION:</b> Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-883-2177. (ATS: 711)</p>             |
| <p><b>Русский (Russian)</b><br/> <b>ВНИМАНИЕ:</b> Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-883-2177. (телетайп: 711)</p>                           | <p><b>한국어 (Korean)</b><br/> <b>주의:</b> 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-883-2177. (TTY: 711)</p>                                                                                    |
| <p><b>Af Soomaali (Somali)</b><br/> <b>OGAYSII:</b> Haddii aad ku hadasho afka soomaaliga, Waxaa kuu diyaar ah caawimaad xagga luqadda ah oo bilaash ah. Fadlan soo wac 1-800-883-2177. (TTY: 711)</p> | <p><b>Tagalog (Tagalog)</b><br/> <b>PAUNAWA:</b> Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-883-2177. (TTY: 711)</p> |



|                                                                                                                                                                                                                         |                                                                                                                                                                                                             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Oromiffa (<i>Cushite [Oromo]</i>)<br/> XIYEEFFANNA: Afaan dubbattu Oromiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-883-2177. (TTY: 711)</p>                                     | <p>Italiano (<i>Italian</i>)<br/> ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-883-2177. (TTY: 711)</p>      |
| <p>አማርኛ (<i>Amharic</i>)<br/> ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-883-2177. (መስማት ለተሳናቸው፡ 711)</p>                                                                 | <p>ภาษาไทย (<i>Thai</i>)<br/> เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-883-2177. (TTY: 711)</p>                                                                            |
| <p>unD (<i>Karen</i>)<br/> ဟ်သုဉ်ဟ်သး- နမ့ၢ်ကတိၤ ကညိၣ် ကျိၣ်အသိၣ်, နမၤန့ၢ် ကျိၣ်အတၢ်မၤစၢၤလၢ တလၢၢ်ဘျုးလၢၢ်စ့ၤ နိတမံၤဘၣ်သ့န့ၣ်လီၤ. ကိး 1-800-883-2177. (TTY: 711)</p>                                                     | <p>ελληνικά (<i>Greek</i>)<br/> ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-883-2177. (TTY: 711)</p>                |
| <p>ខ្មែរ (<i>Mon-Khmer, Cambodian</i>)<br/> ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 1-800-883-2177. (TTY: 711)</p>                                      | <p>Diné Bizaad (<i>Navajo</i>)<br/> Díí baa akó nínízin: Díí saad bee yáníłti'go <b>Diné Bizaad</b>, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, kójjí' hódíílnih 1-800-883-2177. (TTY: 711)</p> |
| <p>Deutsch (<i>Pennsylvanian Dutch</i>)<br/> Wann du Deutsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-883-2177. (TTY: 711)</p> | <p>Ikirundi (<i>Bantu – Kirundi</i>)<br/> ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-883-2177. (TTY: 711)</p>                                     |
| <p>Polski (<i>Polish</i>)<br/> UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-883-2177. (TTY: 711)</p>                                                        | <p>Kiswahili (<i>Swahili</i>)<br/> KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-800-883-2177. (TTY: 711)</p>                                             |
| <p>हिंदी (<i>Hindi</i>)<br/> ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-883-2177. (TTY: 711)</p>                                                                      | <p>日本語 (<i>Japanese</i>)<br/> 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-883-2177 (TTY: 711) まで、お電話にてご連絡ください。</p>                                                                                              |
| <p>Shqip (<i>Albanian</i>)<br/> KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-883-2177. (TTY: 711)</p>                                           | <p>नेपाली (<i>Nepali</i>)<br/> ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-883-2177 (टिडिवाइ: 711)</p>                  |
| <p>Srpsko-hrvatski (<i>Serbo-Croatian</i>)<br/> OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-883-2177. (TTY: 711)</p>                                    | <p>Norsk (<i>Norwegian</i>)<br/> MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-800-883-2177. (TTY: 711)</p>                                                 |
| <p>ગુજરાતી (<i>Gujarati</i>)<br/> સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-883-2177. (TTY: 711)</p>                                                              | <p>Adamawa (<i>Fulfulde, Sudanic</i>)<br/> MAANDO: To a waawi Adamawa, e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-800-883-2177. (TTY: 711)</p>                                                   |
| <p>اُردُو (<i>Urdu</i>)<br/> خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں 1-800-883-2177 (TTY: 711)</p>                                                                    | <p>Українська (<i>Ukranian</i>)<br/> УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-883-2177. (телетайп: 711)</p> |