BlueCross BlueShield Minnesota

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Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
ALLINA HEALTH FIRST (ALT) PLAN

Coverage Period: Beginning on or after 01/01/2025
Coverage for: Individual/Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bluecrossmn.comAllina or call 1-800-509-5310, select option 1. 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 https://www.healthcare.gov/sbc-glossary or call 1-800-509-5310, select option 1 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$500 individual / $1,000 family medical and drug combined in-network, extended in-network and out-of-network	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. This plan has an embedded deductible. 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?	Yes. Well child care, prenatal care and in-network preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. 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 deductibles for specific services.
What is the out-of-pocket limit for this plan?	$4,000 individual / $8,000 family medical combined in-network, extended in-network and out-of-network $1,000 individual/family prescription drug Allina First in-network $2,000 individual/family prescription drug National in-network	The out-of-pocket limit is the most you could pay in a year for covered services. This plan has an embedded out-of-pocket limit. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges (unless balanced billing is prohibited),	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

	and health care this plan doesn't cover.	
Will you pay less if you use an in-network provider?	Yes. See https://www.bluecrossmn.com/Allina or call 1-800-509-5310, select option 1 for a list of in-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 in-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	What You Will Pay if You Use In-Network Providers (You will pay the least)	What You Will Pay if You Use Extended In-Network Providers	Out-of-Network Providers (You will pay the most)	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay/office visit, deductible does not apply for the office visit; 10% coinsurance for all other services	$25 copay/office visit, deductible does not apply for the office visit; 20% coinsurance for all other services	Not covered	None
	Specialist visit	15% coinsurance/office visit, deductible does not apply for the office visit; 10% coinsurance for all other services	30% coinsurance/office visit, deductible does not apply for the office visit; 20% coinsurance for all other services	Not covered	None
	Preventive care/screening/ immunization	No charge	No charge	Not covered	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)	10% coinsurance	20% coinsurance	Not covered	May require prior authorization
	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% coinsurance	Not covered	

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If you need drugs to treat your illness or condition. A retail pharmacy is any licensed pharmacy that you can physically enter to obtain a prescription drug. A mail service pharmacy dispenses prescription drugs through the U.S. Mail.	Preferred generic drugs	Allina First Network $0 copay/prescription (retail) $0 copay/prescription (mail service)	National Network $8 copay/prescription (retail) Not covered (mail service)	Not covered	Covers up to a 31-day supply (retail prescription);32-93-day supply (mail order prescription). Mail service only available through Allina Health pharmacies.
	Preferred brand drugs	Allina First Network 25% coinsurance/ prescription (retail) 25% coinsurance/ prescription (mail service)	National Network 40% coinsurance/ prescription (retail) Not covered (mail service)	Not covered	
	Non-preferred brand drugs	Allina First Network 50% coinsurance/ prescription (retail) 50% coinsurance/ prescription (mail service)	National Network 60% coinsurance/ prescription (retail) Not covered (mail service)	Not covered	
	Specialty drugs	Available through Allina Health Pharmacy. Refer to applicable prescription drug cost-sharing unless included on the SaveonSP Specialty drugs list. For a list of drugs and associated copays included in SaveonSP, go to www.saveonsp.com/allina	Not covered	Not covered	No coverage for services from out-of-network providers. If an Allina Health Pharmacy is unable to fill a specialty drug you must receive an override from the Allina Health Pharmacy to fill the drug with the Express Scripts specialty drug pharmacy, Accredo
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	$250 copay/per occurrence; 40% coinsurance	Not covered	May require prior authorization
	Physician/surgeon fee	15% coinsurance	15% coinsurance	Not covered	May require prior authorization

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If you need immediate medical attention	Emergency room care	25% coinsurance	25% coinsurance	25% coinsurance	None
	Emergency medical transportation	15% coinsurance	15% coinsurance	15% coinsurance	None
	Urgent care	10% coinsurance, deductible does not apply	20% coinsurance, deductible does not apply	25% coinsurance, deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	$250 copay/per occurrence; 40% coinsurance	Not covered	None
	Physician/surgeon fee	15% coinsurance	15% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance use services	Outpatient services	$10 copay/visit; deductible does not apply; no charge for all other services	$10 copay/visit, deductible does not apply; no charge for all other services	Not covered	Services for marriage/couples counseling are not covered. May require prior authorization
	Inpatient services including residential adult mental health treatment	10% coinsurance for facility charges; 15% coinsurance for all other services	10% coinsurance for facility charges; 15% coinsurance for all other services	Not covered	
If you are pregnant	Office visits	Prenatal care: No charge Postnatal care: $25 copay/physician office visit or 15% coinsurance/ specialist office visit, deductible does not apply for the office visit; 15% coinsurance for all other services	Prenatal care: No charge Postnatal care: $25 copay/physician office visit or 30% coinsurance/specialist office visit, deductible does not apply for the office visit; 15% coinsurance for all other services	Not covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, other cost-sharing may apply. Maternity care may include tests and services described elsewhere in the SBC (ie. ultrasound).
	Childbirth/delivery professional services	15% coinsurance	15% coinsurance	Not covered	

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	Childbirth/delivery facility services	10% coinsurance	$250 copay/per occurrence; 40% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	15% coinsurance deductible does not apply	15% coinsurance deductible does not apply	Not covered	Combined all Networks: 120 visits per benefit period. May require prior authorization
	Rehabilitation services	10% coinsurance for occupational therapy, physical therapy, and speech therapy	20% coinsurance for occupational therapy, physical therapy, and speech therapy	Not covered for occupational therapy, physical therapy, and speech therapy	
	Habilitation services	10% coinsurance for occupational therapy, physical therapy, and speech therapy	20% coinsurance for occupational therapy, physical therapy, and speech therapy	Not covered for occupational therapy, physical therapy, and speech therapy	
	Skilled nursing care	15% coinsurance	15% coinsurance	Not covered	May require prior authorization
	Durable medical equipment	10% coinsurance	20% coinsurance	Not covered	May require prior authorization
	Hospice service	10% coinsurance	20% coinsurance	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	Not covered	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 (except as specified in plan benefits)
- Cosmetic surgery (except as specified in plan benefits)
- Dental care (Adult) (and children) (except as specified in plan benefits)
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Infertility

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 Minnesota Department of Commerce at 1 800-657-3602; the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or, Department of Health and Human Services, Center for Consumer Information, and Insurance Oversight, at 1-877-267-2323 x 61565 or www.cciio.cms.gov. For more information on your rights to continue coverage, contact Blue Cross at 1-866-873-5943. 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.mnsure.org or call 1-855-366-7873.

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: Blue Cross at 1-800-509-5310, select option 1; Minnesota Department of Commerce at 1 800-657-3602; the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. If you are covered under a plan offered by the State Health Plan, a city, county, school district, Service Cooperative, or church plan, you may contact the Department of Health and Human Services Health Insurance team at 1-888-393-2789.

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-903-2583.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-537-7720.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-855-315-4017.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-902-2583.

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 prenatal care and a hospital delivery)

The plan's overall deductible	**$500**
Specialist coinsurance	**15%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	$500
Copayments	$0
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,660**

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

The plan's overall deductible	**$500**
Specialist coinsurance	**15%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	$500
Copayments	$80
Coinsurance	$60
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$660**

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

The plan's overall deductible	**$500**
Specialist coinsurance	**15%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	$500
Copayments	$0
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$900**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Notice of Nondiscrimination and Accessibility

At Blue Cross and Blue Shield of Minnesota, 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 **1-855-903-2583**, TTY **711** or call the number on the back of your member identification card.

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 by contacting our Nondiscrimination Civil Rights Coordinator:

Email: Civil.Rights.Coord@bluecrossmn.com
Telephone: 1-800-509-5312
Mail: Blue Cross and Blue Shield of Minnesota ATTN:
Civil Rights Coordinator P3-2
PO Box 64560, Eagan, MN 55164-0560

Or
Email: GrievanceCoordinator@allina.com
Telephone: 612-262-0900
Mail: Allina Health Grievance Coordinator
P.O. Box 43
Minneapolis, MN 55440-0043

Nondiscrimination complaint forms are available on our website at bluecrossmn.com/NDL, or from the Nondiscrimination Civil Rights Coordinator. 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 rights complaint forms are available at hhs.gov/ocr/office/file/index.html

Language Access Services:

ENGLISH ATTENTION: If you speak a language other than English, language services are available free of charge. If you have a vision, hearing, or speech impairment, we can communicate in a way that works best for you. This may include using sign language interpreters, providing documents in large print or Braille, audio recordings, or other aids at no charge. Call 1-855-903-2583 (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 1-855-903-2583 聽障熱線 (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 1-855-903-2583 (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 1-855-903-2583 (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። 1-855-903-2583 (TTY 711) ላይ ይደውሉ።	**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 1-855-903-2583 (ATS 711).
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 1-855-903-2583 (TTY 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 1-855-903-2583 (TTY 711).
ខ្មែរ (Khmer) ការជូនដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ អ្នកអាចប្រើសេវាជំនួយភាសាបោយឥតគិតថ្លៃ។ ប្រសិនបើអ្នកមិនបញ្ជាក់ឬនិយាយមិនបាន បើអាចប្រាស័យទាក់ទងជាមួយអ្នកតាមរបៀបសេងជុលមានប្រសិទធភាពលអំសត សមារអ្នក។ ការប្រាស័យទាក់ទងបនេះអាចមានជូចជាអ្នកភាសាសញ្ញា ការសាល់ឯកសារខ្ពលបបាេះពុមពអក្សរធំៗ ឬអ្ករសារ ឬការលទកជាសំឡេង ឬជំនួយ បសេងបទៀត បោយឥតគិតថ្លៃ។ ទូរសពបៅបលម 1-855-903-2583 (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. 1-855-903-2583 (TTY 711) 번으로 전화하십시오.

ကညီကျိာ် (Karen)
ပ ာ်သ ာ်ပ ာ်သး- နမ့်ၤ တ ိၤ ကညီကျိာ် န ာ်, နၤဃ က ာ်ဂီၢ တ့်ၤ စ ိၤမိၤစ ိၤလ တလ ာ်ဘ းလဲ သန ာ်လီၢ်ိၤ. နမ့်ၤ ာ်ဒိးတ့်ၤ လ တပ ဲိၤလ မဲ ာ်တ့်ၤ ာ်, တ်နၤ့်, မတမ ာ်တ်စးကတိၤတ်နၤ့် ပဆဲးက ဆဲးက းတ့်ၤ ကဲ ကဲထီ ာ်လ ာ်ထီ ာ်အဂ ိၤကတ့်ၤ နဂီ့်ၤ န ာ်လီၢ်ိၤ. တ့်ၤ ိၤ ပ ာ်ဃ ာ်ဒီး တ်စ းကါ နီ်ခ ကီၢ ိၤက ာ်အပ ိၤက ာ်ထ တ့်ၤ ဖ ာ်, တ့်ၤ ာ်လ ာ်လဲ့်ၤ ဖ ာ်လ အလ ာ်ဖ ာ်ဖးဒ ာ်, မတမ ာ်ပ ိၤမဲ ာ်ဘီ ာ်အလ ာ်, တ့်ၤ လ ာ်မတမ ာ်တ်ခိၤစ ိၤဂ ိၤဂိၤတဖ့်ၤ လ တလ ာ်အဘ းလဲန ာ်လီၢ်ိၤ. က းလီတဲစ ဆ 1-855-903-2583 (TTY 711) တက ိၤ.ာ်

မြန်မာဘာသာ (Burmese)
သတ ပပြုရန်- သင်သည် ပမန်မ ဘ သ စက းက ပပပ ပါက၊ အခမဲ ဘ သ စက း အက အညီ ဝန်ပဆ င်မှုမ းက ပတ င်းဆ နင်ပါသည်။ သင်တွင် အပမင်အ ရ၊ အကက းအ ရ သမ ဟုတ် စက းပပပ ပခင်း ခ ြုယွင်းမှုရှ ပနပါက သင်အတွက် အသင ် ပလ ာ်ဆ းပဖစ်မည့်နည်းလမ်းပဖင့် ကျွန်ုပ်တ ထသ ဆက်သွယ်နင်ပါသည်။ ၎င်းတွင် လက်ဟန်ပပဘ သ စက း စက းပပန်မ းက အသ းပပြုပခင်း၊ စ ရွက်စ တမ်းမ းက ပ န ်စ လ းကကီးမ း သမဟုတ် မ က်မပမင်စ ပဖင့်

ပပးပပးပခင်း၊ အသဖမ်းယ ပခင်းမ း သမဟုတ် အပခ းအပထ က်အကမ းပဖင့် အခမဲ ပပးပပးပခင်းတ ပါဝင်ပါသည်။ 1-855-903-2583 (TTY 711) သ ဖ န်းပခေါ်ဆ ပါ။

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. 1-855-903-2583 (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 1-855-903-2583 (TTY 711).

ພາສາລາວ (Lao)
ເອົາໃຈໃສ່: ຖາ້ທ່ານເວົ້າ ພາສາລາວ, ທ່ານສາມາດຂໍບໍລິການຊ່ວຍເຫຼືອດາ້ນພາສາໄດໂ້ດຍບໍ່ເສຍຄ່າ. ຖາ້ທ່ານມີຄວາມບົກຜ່ອງດາ້ນສາຍຕາ, ການໄດຍ້ິນ ຫຼື ການປາກເວົ້າ, ພວກເຮົາສາມາດສ່ືສານດວ້ຍວິທີທີ່ເໝາະສົມກັບທ່ານທີ່ສຸດ. ອັນນີ້ອາດຈະລວມເຖິງການໃຊນ້າຍພາສາມື, ການຈັດກຽມເອກະສານເປັນໂຕພິມໃຫຍ່ ຫຼື ອັກສອນນູນ, ການບັນທຶກສຽງ ຫຼື ການຊ່ວຍເຫຼືອດາ້ນສ່ືອ່ືນໆໂດຍບໍ່ ເສຍຄ່າໃຊຈ້່າຍໃດໆ. ໂທ 1-855- 903-2583 (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
1-855-903-2583 (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
1-855-903-2583 (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 1-855-903-2583（文字电话 711）。

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