



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call your Coupe Health Valet at 1-833-749-1969 or visit us at [CoupeHealth.com](https://www.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 <a href="#">deductible</a> ?	Tier 1-3 In-Network \$0	Tier 4 Out-of-Network \$0	There is no overall <a href="#">deductible</a> for this <a href="#">plan</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Tier 1-3 In-Network Yes. There is no overall calendar year <a href="#">deductible</a>	Tier 4 Out-of-Network Yes. There is no overall calendar year <a href="#">deductible</a>	<a href="#">Deductible</a> does not apply for this plan. But a <a href="#">copayment</a> may apply. This <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits">https://www.healthcare.gov/coverage/preventive-care-benefits</a> .
Are there other <a href="#">deductibles</a> for specific services?	No		You don't have to meet <a href="#">deductible</a> for specific services, but see the chart starting on page 2 for other costs for services this <a href="#">plan</a> covers.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Tier 1-3 In-Network Employee / \$3,500 Family / \$7,000	Tier 4 Out-of-Network Employee / \$7,000 Family / \$14,000	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. This limit helps you plan for health care expenses. This <a href="#">plan</a> has a per member <a href="#">out-of-pocket limit</a> . Once a family member reaches his or her <a href="#">out-of-pocket limit</a> , the <a href="#">plan</a> begins to pay 100% of eligible health care expenses for that person for the rest of the year.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance billing</a> charges, health care this <a href="#">plan</a> doesn't cover, and pre-certification penalties.		Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="https://www.coupehealth.com">CoupeHealth.com</a> or call 1-833-749-1969 for a list of <a href="#">network providers</a> .		This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No		You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1 In-Network	Tier 2 In-Network	Tier 3 In-Network	Tier 4 Out-of-Network	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$15 <a href="#">copay</a>	\$35 <a href="#">copay</a>	\$65 <a href="#">copay</a>	\$120 <a href="#">copay</a>	None
	<a href="#">Specialist</a> visit	\$25 <a href="#">copay</a>	\$65 <a href="#">copay</a>	\$100 <a href="#">copay</a>	\$160 <a href="#">copay</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No Charge	No Charge	No Charge	\$120 <a href="#">copay</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive, then check what your <a href="#">plan</a> will pay for  Additional services are available. Please call your Coupe Health Valet at 1-833-749-1969.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	Routine Labs: \$0 <a href="#">copay</a> Advanced Labs: \$150 <a href="#">copay</a> X-ray: \$70 <a href="#">copay</a>	Routine Labs: \$10 <a href="#">copay</a> Advanced Labs: \$250 <a href="#">copay</a> X-ray: \$90 <a href="#">copay</a>	Routine Labs: \$30 <a href="#">copay</a> Advanced Labs: \$500 <a href="#">copay</a> X-ray: \$150 <a href="#">copay</a>	Routine Labs: \$50 <a href="#">copay</a> Advanced Labs: \$650 <a href="#">copay</a> X-ray: \$180 <a href="#">copay</a>	Fees listed include facility and physician charges.
	Imaging (CT/PET scans, MRIs)	\$150 <a href="#">copay</a>	\$400 <a href="#">copay</a>	\$800 <a href="#">copay</a>	\$1,000 <a href="#">copay</a>	None

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1 In-Network	Tier 2 In-Network	Tier 3 In-Network	Tier 4 Out-of-Network	
<b>If you need drugs to treat your illness or condition</b>  A retail pharmacy is any licensed pharmacy that you can physically enter to obtain a <a href="#">prescription drug</a> . A mail service pharmacy dispenses <a href="#">prescription drugs</a> through the U.S. Mail.  More information about <a href="#">prescription drug coverage</a> is available at <a href="#">OptumRx.com</a>	Tier 1 <a href="#">Prescription Drugs</a> - Your Lowest-Cost Option	Retail: 25% <a href="#">coinsurance</a> Mail Order: 25% <a href="#">coinsurance</a>	Retail: 25% <a href="#">coinsurance</a> Mail Order: 25% <a href="#">coinsurance</a>	Retail: 25% <a href="#">coinsurance</a> Mail Order: 25% <a href="#">coinsurance</a>	Not Covered	Retail: 25% (\$25 min/\$125 max <a href="#">copay</a> ) Mail Order: 25% (\$50 min/\$250 max <a href="#">copay</a> ) Tier 1 contraceptives 100%
	Tier 2 <a href="#">Prescription Drugs</a> - Your Midrange-Cost Option	Retail: 40% <a href="#">coinsurance</a> Mail Order: 40% <a href="#">coinsurance</a>	Retail: 40% <a href="#">coinsurance</a> Mail Order: 40% <a href="#">coinsurance</a>	Retail: 40% <a href="#">coinsurance</a> Mail Order: 40% <a href="#">coinsurance</a>	Not Covered	Retail: 40% (\$50 min/\$200 max <a href="#">copay</a> ) Mail Order: 40% (\$100 min/\$400 max <a href="#">copay</a> )
	Tier 3 <a href="#">Prescription Drugs</a> - Your Highest-Cost Option	Retail: 50% <a href="#">coinsurance</a> Mail Order: 50% <a href="#">coinsurance</a>	Retail: 50% <a href="#">coinsurance</a> Mail Order: 50% <a href="#">coinsurance</a>	Retail: 50% <a href="#">coinsurance</a> Mail Order: 50% <a href="#">coinsurance</a>	Not Covered	Retail: 50% (\$75 min/\$300 max <a href="#">copay</a> ) Mail Order: 50% (\$150 min/\$600 max <a href="#">copay</a> )
	Tier 4 <a href="#">Prescription Drugs</a> - Your Additional High-Cost Option	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered; member pays 100%
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$150 <a href="#">copay</a>	\$300 <a href="#">copay</a>	\$650 <a href="#">copay</a>	\$1,300 <a href="#">copay</a>	Facility fee listed includes facility and physician charges associated with outpatient facility and surgical services
	Physician/surgeon fees	No Charge	No Charge	No Charge	No Charge	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$600 <a href="#">copay</a>	\$600 <a href="#">copay</a>	\$600 <a href="#">copay</a>	\$600 <a href="#">copay</a>	Copay is waived if admitted within 24 hours. Out-of-network emergency room care visit copay applies to the in-network out-of-pocket limit.
	<a href="#">Emergency medical transportation</a>	\$550 <a href="#">copay</a>	\$550 <a href="#">copay</a>	\$550 <a href="#">copay</a>	\$550 <a href="#">copay</a>	Out-of-network copay applies to the in-network out-of-pocket limit.
	<a href="#">Urgent care</a>	\$60 <a href="#">copay</a>	\$75 <a href="#">copay</a>	\$120 <a href="#">copay</a>	\$210 <a href="#">copay</a>	None

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1 In-Network	Tier 2 In-Network	Tier 3 In-Network	Tier 4 Out-of-Network	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$1,400 <a href="#">copay</a>	\$1,600 <a href="#">copay</a>	\$2,200 <a href="#">copay</a>	\$2,600 <a href="#">copay</a>	Prior authorization is required for non-emergency facility admissions and inpatient surgery or there may be no coverage
	Physician/surgeon fees	No Charge	No Charge	No Charge	No Charge	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$80 <a href="#">copay</a>	\$100 <a href="#">copay</a>	\$150 <a href="#">copay</a>	\$200 <a href="#">copay</a>	Inpatient services include facility and physician charges  EAP Visit Limit: 8 per issue
	Inpatient services	\$1,400 <a href="#">copay</a>	\$1,600 <a href="#">copay</a>	\$2,200 <a href="#">copay</a>	\$2,600 <a href="#">copay</a>	
If you are pregnant	Office visits	No Charge	No Charge	No Charge	No Charge	One <a href="#">copayment</a> is applied for all covered services related to childbirth/delivery, including the newborn, unless discharged after mother
	Childbirth/delivery professional services	No Charge	No Charge	No Charge	No Charge	
	Childbirth/delivery facility services	\$800 <a href="#">copay</a>	\$1,200 <a href="#">copay</a>	\$2,000 <a href="#">copay</a>	\$2,500 <a href="#">copay</a>	Prior authorization is required for inpatient stays beyond 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery or there may be no coverage

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1 In-Network	Tier 2 In-Network	Tier 3 In-Network	Tier 4 Out-of-Network	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	\$50 <a href="#">copay</a>	\$65 <a href="#">copay</a>	\$110 <a href="#">copay</a>	\$130 <a href="#">copay</a>	Visit Limit: 120 per person per calendar year combined in-network and out-of-network.  Prior authorization is required for certain home health care services or there may be no coverage
	<a href="#">Rehabilitation services</a>	\$15 <a href="#">copay</a>	\$35 <a href="#">copay</a>	\$65 <a href="#">copay</a>	\$120 <a href="#">copay</a>	Visit Limit: 120 per person per calendar year in-network and out-of-network for occupational therapy, physical therapy, and speech therapy combined
	<a href="#">Habilitation services</a>	\$15 <a href="#">copay</a>	\$35 <a href="#">copay</a>	\$65 <a href="#">copay</a>	\$120 <a href="#">copay</a>	Mental health-related therapies (occupational, physical and speech): Visit limits do not apply
	<a href="#">Skilled nursing care</a>	\$1,400 <a href="#">copay</a>	\$1,600 <a href="#">copay</a>	\$2,200 <a href="#">copay</a>	\$2,600 <a href="#">copay</a>	Prior authorization is required or there may be no coverage
	<a href="#">Durable medical equipment</a>	\$110 <a href="#">copay</a>	\$145 <a href="#">copay</a>	\$240 <a href="#">copay</a>	\$290 <a href="#">copay</a>	Diabetic equipment and supplies provided by Omada are covered at \$0 <a href="#">copay</a> ; other providers will be subject to the applicable Tier <a href="#">copay</a>
	<a href="#">Hospice services</a>	\$260 <a href="#">copay</a>	\$350 <a href="#">copay</a>	\$580 <a href="#">copay</a>	\$695 <a href="#">copay</a>	Prior authorization is required or there may be no coverage
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	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](#).)

- |  |  |                        |
|--|--|------------------------|
| • Adult routine vision exam (i.e., refraction) | • Cosmetic surgery                                   | • Private-duty nursing |
| • Child routine vision exam (i.e., refraction) | • Dental care (Adult)                                | • Routine foot care    |
| • Child dental check-up                        | • Long-term care                                     | • Weight Loss Programs |
| • Child glasses                                | • Non-emergency care when traveling outside the U.S. |                        |

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

- |                     |                       |   |
|---------------------|-----------------------|---|
| • Acupuncture       | • Chiropractic care   | • Temporomandibular Joint Dysfunction (TMJ) |
| • Bariatric surgery | • Hearing Aids        |   |
|                     | • Fertility Treatment |   |

**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; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform); or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323, extension 61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). For more information on your rights to continue coverage, contact Blue Cross at 1-866-455-8220. 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.com](http://www.mnsure.com) 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 1-866-455-8220; the 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](http://www.dol.gov/ebsa/healthreform). If you are covered under a [plan](#) offered by the State Health Plan, a city, county, school district, or 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](#).

*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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$25
■ Hospital (facility) <a href="#">copayment</a>	\$800
■ Other <a href="#">copayment/coinsurance</a>	\$600/40%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,600
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,660</b>

### Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$25
■ Hospital (facility) <a href="#">copayment</a>	\$800
■ Other <a href="#">copayment/coinsurance</a>	\$600/40%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$1,200
What isn't covered	
Limits or exclusions	\$40
<b>The total Joe would pay is</b>	<b>\$1,640</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$25
■ Hospital (facility) <a href="#">copayment</a>	\$800
■ Other <a href="#">copayment/coinsurance</a>	\$600/40%

This EXAMPLE event includes services like:

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

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

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,700
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,700</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



## 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, kwijigo holne' 1-855-902-2583.

## Notice of Nondiscrimination Practices

### ***Effective July 18, 2016***

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender. Blue Cross does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

Blue Cross provides resources to access information in alternative formats and languages:

- Auxiliary aids and services, such as qualified interpreters and written information available in other formats, are available free of charge to people with disabilities to assist in communicating with us.
- Language services, such as qualified interpreters and information written in other languages, are available free of charge to people whose primary language is not English.

If you need these services, contact us at 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711.

If you believe that Blue Cross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or gender, you can file a grievance with the Nondiscrimination Civil Rights Coordinator

- by email at: [Civil.Rights.Coord@bluecrossmn.com](mailto:Civil.Rights.Coord@bluecrossmn.com)
- by mail at: Nondiscrimination Civil Rights Coordinator  
Blue Cross and Blue Shield of Minnesota and Blue Plus  
M495  
PO Box 64560  
Eagan, MN 55164-0560
- or by telephone at: 1-800-509-5312

Grievance forms are available by contacting us at the contacts listed above, by calling 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711. If you need help filing a grievance, assistance is available by contacting us at the numbers listed above.

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

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.



## Language Access Services:

This information is available in other languages. Free language assistance services are available by calling the toll free number below. For TTY, call 711.

Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al 1-855-903-2583. Para TTY, llame al 711.

Yog tias koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau 1-800-793-6931. Rau TTY, hu rau 711.

Haddii aad ku hadasho Soomaali, adigu waxaad heli kartaa caawimo luqad lacag la'aan ah. Wac 1-866-251-6736. Markay tahay dad maqalku ku adag yahay (TTY), wac 711.

နမ့်ကတိကညိကျိန်နိး, တကယ့်နကိတ်တမၤကလိတဖၣ်န့ၣ်လိၤ. ကိး 1-866-251-6744 လၢ TTYအဂီၢ်, ကိး 711 တက့ၢ်.

إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 1-866-569-9123. للهاتف النصي اتصل بالرقم 711.

Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Gọi số 1-855-315-4015. Người dùng TTY xin gọi 711.

Afaan Oromoo dubbattu yoo ta'e, tajaajila gargaarsa afaan hiikuu kaffaltii malee. Argachuuf 1-855-315-4016 bilbilaa. TTY dhaaf, 711 bilbilaa.

如果您說中文，我們可以為您提供免費的語言協助服務。請撥打 1-855-315-4017。聽語障專 (TTY)，請撥打 711。

Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Звоните 1-855-315-4028. Для использования телефонного аппарата с текстовым выходом звоните 711.

Si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le +1-855-315-4029. Pour les personnes malentendantes, appelez le 711.

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한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 1-855-904-2583 으로 전화하십시오. TTY 사용자는 711 로 전화하십시오.

ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອພາສາໃຫ້ເຈົ້າຟຣີ. ໃຫ້ໂທຫາ 1-866-356-2423 ສໍາລັບ. TTY, ໃຫ້ໂທຫາ 711.

Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo sa wika. Tumawag sa 1-866-537-7720. Para sa TTY, tumawag sa 711.

Wenn Sie Deutsch sprechen, steht Ihnen fremdsprachliche Unterstützung zur Verfügung. Wählen Sie 1-866-289-7402. Für TTY wählen Sie 711.

Diné k'ehjí yánílt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Kojí éí béésh bee hodíílnih 1-855-902-2583. TTY biniiyégo éí 711 jì' béésh bee hodíílnih.

ប្រសិនបើអ្នកនិយាយភាសាខ្មែរមិន អ្នកអាចរកបានសេវាជំនួយភាសាឥតគិតថ្លៃ។ ទូរស័ព្ទមកលេខ 1-855-906-2583។ សម្រាប់ TTY សូមទូរស័ព្ទមកលេខ 711។