



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 us at [www.AveraHealthPlans.com](http://www.AveraHealthPlans.com) or call 1-888-322-2115. 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 1-888-322-2115 to request a copy.

Important Questions	Answers	Why this Matters
What is the overall <a href="#">deductible</a> ?	In-Network \$6,000 Individual or \$12,000 Family. Out-of-Network \$10,000 Individual or \$20,000 Family. Does not apply to pharmacy. <a href="#">Co-pays</a> do not count toward any <a href="#">deductibles</a> .	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a copayment or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</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?	Yes. \$50 pharmacy <a href="#">deductible</a> per member or \$100 pharmacy <a href="#">deductible</a> per family.	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	In-Network \$8,150 Individual or \$16,300 Family and there is no <a href="#">out-of-pocket limit</a> for <a href="#">out-of-network</a> .	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance billed</a> charges, and health care services this <a href="#">plan</a> does not cover.	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="http://www.AveraHealthPlans.com">www.AveraHealthPlans.com</a> or call 1(888) 322-2115 for a list of network providers.	This <a href="#">plan</a> uses a provider <a href="#">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	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	<a href="#">Primary care</a> visit to treat an injury or illness	50% <a href="#">coinsurance</a> after deductible	50% <a href="#">coinsurance</a> after deductible	Each family member will receive the first three office visit <a href="#">co-pays</a> at \$50 per person per year. This includes Primary Care Physician, Chiropractic, Mental Health, Urgent Care, Habilitation or Rehabilitation visits. After 3 visits, subject to <a href="#">deductible</a> and <a href="#">coinsurance</a> .
	<a href="#">Specialist</a> visit	50% <a href="#">coinsurance</a> after deductible	50% <a href="#">coinsurance</a> after deductible	---none---
	Chiropractic visit	50% <a href="#">coinsurance</a> after deductible	Not covered	Each family member will receive the first three office visit <a href="#">co-pays</a> at \$50 per person per year. This includes Primary Care Physician, Chiropractic, Mental Health, Urgent Care, Habilitation or Rehabilitation visits. After 3 visits, subject to <a href="#">deductible</a> and <a href="#">coinsurance</a> . <a href="#">Preauthorization</a> is required after 20 chiropractic visits per <a href="#">plan</a> year. No coverage for services without <a href="#">preauthorization</a> .
	<a href="#">Preventive care</a> / <a href="#">screening</a> /immunization	No charge	Not covered	Age and frequency limitations may apply. You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	50% <a href="#">coinsurance</a> after deductible	50% <a href="#">coinsurance</a> after deductible	---none---
	Imaging (CT/PET scans, MRIs)	50% <a href="#">coinsurance</a> after deductible	50% <a href="#">coinsurance</a> after deductible	Some imaging requires <a href="#">preauthorization</a> . Major lab and X-ray services may include PET scan, MRI, CT scan, SPECT scan, cardiovascular, nuclear medicine and MRA.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations, Exceptions, & Other Important Information
<b>If you need drugs to treat your illness or condition</b>  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.avera.org/marketplace/drug-formulary/">www.avera.org/marketplace/drug-formulary/</a>	Tier 1: Preventive medications	No charge	Not covered	Prescription drugs are subject to a \$50 <a href="#">deductible</a> per member and \$100 <a href="#">deductible</a> per family per calendar year for tiers 2 through 6. Certain drugs require <a href="#">preauthorization</a> . The <a href="#">preauthorization</a> for the drug must be approved before the drug will be covered. After prescription drug <a href="#">deductible</a> has been met, Tier 6 out of pocket maximum is \$250 per prescription.
	Tier 2: Preferred Generics and some brand medications	\$15 <a href="#">co-pay</a> for 30-day supply after deductible	Not covered	
	Tier 3: Non-preferred generics and some brand medications	\$35 <a href="#">co-pay</a> for 30-day supply after deductible	Not covered	
	Tier 4: Preferred brand medications	\$75 <a href="#">co-pay</a> for 30-day supply after deductible	Not covered	
	Tier 5: Non-preferred brand medications	\$150 <a href="#">co-pay</a> for 30-day supply after deductible	Not covered	
	Tier 6: Specialty medications, brand and generic	40% <a href="#">coinsurance</a> after deductible. \$250 maximum	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	50% <a href="#">coinsurance</a> after deductible	50% <a href="#">coinsurance</a> after deductible	---none---
	Physician/surgeon fees	50% <a href="#">coinsurance</a> after deductible	50% <a href="#">coinsurance</a> after deductible	---none---
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	50% <a href="#">coinsurance</a> after deductible	50% <a href="#">coinsurance</a> after deductible	---none---
	<a href="#">Emergency medical transportation</a>	50% <a href="#">coinsurance</a> after deductible	50% <a href="#">coinsurance</a> after deductible	<a href="#">Preauthorization</a> for non-emergency transportation. No coverage for services without <a href="#">preauthorization</a> .
	<a href="#">Urgent care</a>	50% <a href="#">coinsurance</a> after deductible	50% <a href="#">coinsurance</a> after deductible	Each family member will receive the first three office visit <a href="#">co-pays</a> at \$50 per person per year. This includes Primary Care Physician, Chiropractic, Mental Health, Urgent Care, Habilitation or Rehabilitation visits. After 3 visits, subject to <a href="#">deductible</a> and <a href="#">coinsurance</a> . For out-of-network <a href="#">urgent care</a> visits, you may contact the <a href="#">plan</a> to determine if your visit qualifies for in-network benefits.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	50% <a href="#">coinsurance</a> after deductible	50% <a href="#">coinsurance</a> after deductible	<a href="#">Preauthorization</a> required. No coverage for services without <a href="#">preauthorization</a> .
	Physician/surgeon fee	50% <a href="#">coinsurance</a> after deductible	50% <a href="#">coinsurance</a> after deductible	

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations, Exceptions, & Other Important Information
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Outpatient services	Office: 50% <a href="#">coinsurance</a> after deductible	50% <a href="#">coinsurance</a> after deductible	Each family member will receive the first three office visit <a href="#">co-pays</a> at \$50 per person per year. This includes Primary Care Physician, Chiropractic, Mental Health, Urgent Care, Habilitation or Rehabilitation visits. After 3 visits, subject to <a href="#">deductible</a> and <a href="#">coinsurance</a> . Services other than therapy performed in the office or any service at a facility: 50% <a href="#">coinsurance</a> .
	Inpatient services	50% <a href="#">coinsurance</a> after deductible	50% <a href="#">coinsurance</a> after deductible	<a href="#">Preauthorization</a> required. No coverage for services without <a href="#">preauthorization</a> .
<b>If you are pregnant</b>	Office Visits	50% <a href="#">coinsurance</a> after deductible	50% <a href="#">coinsurance</a> after deductible	<a href="#">Cost sharing</a> does not apply to certain preventive services. Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	50% <a href="#">coinsurance</a> after deductible	50% <a href="#">coinsurance</a> after deductible	
	Childbirth/delivery facility services	50% <a href="#">coinsurance</a> after deductible	50% <a href="#">coinsurance</a> after deductible	
<b>If you need help recovering or have other special needs</b>	<a href="#">Home health care</a>	50% <a href="#">coinsurance</a> after deductible	50% <a href="#">coinsurance</a> after deductible	60-visit limit per <a href="#">plan</a> year for services from non-participating providers. One visit equals a maximum of 4 hours, including private duty nursing.
	<a href="#">Rehabilitation services</a>	50% <a href="#">coinsurance</a> after deductible	50% <a href="#">coinsurance</a> after deductible	Each family member will receive the first three office visit <a href="#">co-pays</a> at \$50 per person per year. This includes Primary Care Physician, Chiropractic, Mental Health, Urgent Care, Habilitation or Rehabilitation visits. After 3 visits, subject to <a href="#">deductible</a> and <a href="#">coinsurance</a> . <a href="#">Preauthorization</a> required after 30 visits per <a href="#">plan</a> year for each therapy: physical, occupational and speech. No coverage for services without <a href="#">preauthorization</a> . Cardiac and pulmonary rehab services from participating providers are 50% <a href="#">coinsurance</a> and have a 36-visit maximum per <a href="#">plan</a> year.
	<a href="#">Habilitation services</a>	50% <a href="#">coinsurance</a> after deductible	50% <a href="#">coinsurance</a> after deductible	
	<a href="#">Skilled nursing care</a>	50% <a href="#">coinsurance</a> after deductible	50% <a href="#">coinsurance</a> after deductible	100-day confinement limit for services from participating providers. 60-day confinement limit for services from non-participating providers. Same confinement limit if readmitted with same diagnosis within 60 days.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special needs	<a href="#">Durable medical equipment</a>	50% <a href="#">coinsurance</a> after deductible	Not covered	Certain <a href="#">durable medical equipment</a> require <a href="#">preauthorization</a> . No coverage for services without <a href="#">preauthorization</a> .
	<a href="#">Hospice service</a>	50% <a href="#">coinsurance</a> after deductible	50% <a href="#">coinsurance</a> after deductible	185-day limit per <a href="#">plan</a> year
If your child needs dental or eye care	Eye exam	No charge	Not covered	One diagnostic exam per calendar year for children under the age of 19 from a VSP provider. Call 1-800-877-7195 or visit <a href="#">VSP.com</a> to find a participating vision provider
	Glasses	No charge	Not covered	Frames from the designated pediatric eyewear collection are covered. Call 1-800-877-7195 or visit <a href="#">VSP.com</a> to find a participating vision provider.
	Dental check-up	No charge	Not covered	Preventive exam every 6 months for children under age of 19. Refer to the Pediatric Dental Addendum for additional coverage details.

### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Does NOT Cover (This isn't a complete list. Check your policy or <a href="#">plan</a> document for other <a href="#">excluded services</a> .)		
• Abortion (Except when the life of the mother is endangered)	• Dental care (Adult)	• Long-term care
• Acupuncture	• Hearing aids	• Routine eye care (Adult)
• Cosmetic surgery	• Infertility treatment	• Weight loss program
• Non-emergency care when traveling outside the United States		

Other Covered Services (This isn't a complete list. Check your policy or <a href="#">plan</a> document for other covered services and your costs for these services.)	
• Bariatric surgery if <a href="#">preauthorization</a> requirements are met	• Routine foot care when part of corrective surgery or for diabetes and metabolic or peripheral vascular disease
• Chiropractic care if provided by a participating provider	• Private-duty nursing

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**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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). 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: the [plan](#) at 1-888-322-2115, 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 the South Dakota Division of Insurance at 605-773-3563.

**Does this Coverage 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 Coverage Meet the Minimum Value Standard? 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 1-888-322-2115.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-322-2115.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-322-2115.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-322-2115.

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*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

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## 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>	\$6,000
■ <a href="#">Specialist copayment</a>	50%
■ Hospital (facility) <a href="#">coinsurance</a>	50%
■ Other <a href="#">coinsurance</a>	50%

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:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$6,000
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$2,200
<i>What isn't covered</i>	
Limits or exclusions	\$100
<b>The total Peg would pay is</b>	<b>\$8,300</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>	\$6,000
■ <a href="#">Specialist copayment</a>	50%
■ Hospital (facility) <a href="#">coinsurance</a>	50%
■ Other <a href="#">coinsurance</a>	50%

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** \$7,400

In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$3,000
<a href="#">Copayments</a>	\$900
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$100
<b>The total Joe would pay is</b>	<b>\$4,000</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>	\$6,000
■ <a href="#">Specialist copayment</a>	50%
■ Hospital (facility) <a href="#">coinsurance</a>	50%
■ Other <a href="#">coinsurance</a>	50%

This EXAMPLE event includes services like:

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

**Total Example Cost** \$1,900

In this example, Mia would pay:

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

# Discrimination is Against the Law

Avera Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Avera Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Avera Health Plans:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact the Avera Health Plans Service Center at 1-888-322-2115, (TTY 711), 8 a.m. to 5 p.m. CST, Monday through Friday.

If you believe that Avera Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Complaint and Appeals Coordinator, Avera Health Plans  
5300 S. Broadband Ln., Sioux Falls, SD 57108-2221  
1-800-322-2115 (phone), TTY 711, 1-800-269-8561 (fax)  
[ComplaintAppeals@AveraHealthPlans.com](mailto:ComplaintAppeals@AveraHealthPlans.com)

You can file a grievance in person or by mail, fax, or email. You may also contact the Complaint and Appeals Coordinator if you need assistance with filing a complaint.

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:

US Department of Health and Human Services,  
200 Independence Avenue SW Room 509F, HHH Building  
Washington, D.C. 20201

1-800-368-1019 or 1-800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

## Getting Help in Other Languages

Para asistencia en su lengua llame a 1-888-322-2115.

- **ATENCIÓN:** Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-322-2115 (TTY: 1-800-877-1113).
- **LUS CEEV:** Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-322-2115 (TTY: 1-800-877-1113).
- **CHÚ Ý:** Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-322-2115 (TTY: 1-800-877-1113).
- **XIYYEEFFANNAA:** Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-322-2115 (TTY: 1-800-877-1113).
- **注意:** 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1-888-322-2115 (TTY: 1-800-877-1113)。
- **ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-322-2115 (TTY: 1-800-877-1113).
- **ВНИМАНИЕ:** Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-322-2115 (телетайп: 1-800-877-1113).

●ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 888-322-2115-1 (رقم هاتف الصم والبكم: 800-877-1113-1).

- **ໂປດຊາບ:** ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອ ອັດຕະໂນພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-888-322-2115 (TTY: 1-800-877-1113).
- **တံသ့တံသး-** နမူကတိ ကညိ ကျိအယိ. နမူနာ ကျိအတိမေၤလၢ တလၢကတံသ့တံသးန့ၢ်လီၤ. ၎် 1-888-322-2115 (TTY: 1-800-877-1113).
- **ATTENTION:** Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-322-2115 (ATS: 1-800-877-1113).
- **주의:** 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-322-2115 (TTY: 1-800-877-1113) 번으로 전화해 주십시오.
- **ማሳሰቢያ:** የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በገን ሊያገዝዎት ተዘጋጅተዋል። ወደ ሚክላው ቁጥር ይደውሉ 1-888-322-2115 (መስማት ለተሳናቸው: 1-800-877-1113).
- **OBAVJEŠTENJE:** Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-322-2115 (TTY - Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-877-1113).
- **ប្រយ័ត្ន:** បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសាដោយមិនគិតល្អៗ គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 1-888-322-2115 (TTY: 1-800-877-1113)។