




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 1-800-322-2115 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	In-Network \$0 Individual or \$0 Family. Out-of-Network \$10,000 Individual or \$20,000 Family. Does not apply to pharmacy. <a href="#">Copays</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> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	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 <a href="#">copayment</a> 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> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	Yes. \$100 pharmacy <a href="#">deductible</a> per individual or \$200 <a href="#">deductible</a> per family. <a href="#">Deductible</a> does not apply to Tier 1, Tier 2, Tier 3, and Tier 5 drugs. There are no other deductibles.	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.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	In-Network Individual \$10,600 or \$21,200 Family and there is no <a href="#">out-of-pocket</a> limit for out-of-network.	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.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<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> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	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.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	<a href="#">Primary care</a> visit to treat an injury or illness	\$50 <a href="#">copay</a> per visit	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	<a href="#">Specialist</a> visit	\$150 <a href="#">copay</a> per visit	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	<a href="#">Preventive care/screening/immunization</a>	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, ultrasound)	\$75 <a href="#">copay</a> per service	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Copay</a> applies when diagnostic test is performed in an office setting. <a href="#">Coinsurance</a> applies when lab or X-ray are sent out or performed in a hospital, surgical center, or outpatient facility.
	Imaging (CT/PET scans, MRIs)	\$900 <a href="#">copay</a> per procedure	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	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.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.averahealthplans.com](http://www.averahealthplans.com)\*

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="http://www.averahealthplans.com/insurance/find-a-prescription-drug/">prescription drug coverage</a> is available at <a href="http://www.averahealthplans.com/insurance/find-a-prescription-drug/">www.averahealthplans.com/insurance/find-a-prescription-drug/</a>	Tier 1: Preventive medications	No charge for 30-day supply	Not covered	Refer to the 2026 Avera Choice Drug List to determine the tier that applies to a covered drug. Prescription drugs are subject to a \$100 <a href="#">deductible</a> per member or \$200 <a href="#">deductible</a> per family per plan year. Certain drugs require <a href="#">preauthorization</a> . The <a href="#">preauthorization</a> for the drug must be approved before the drug will be covered. Deductible does not apply to Tier 1, Tier 2 Tier 3, and Tier 5 drugs.
	Tier 2: Generic medications	\$15 <a href="#">copay</a> for 30-day supply	Not covered	
	Tier 3: Preferred brand medications	\$50 <a href="#">copay</a> for 30-day supply	Not covered	
	Tier 4: Non-preferred brand medications	50% <a href="#">coinsurance</a> after Rx <a href="#">deductible</a> for 30-day supply	Not covered	
	Tier 5: Specialty value medications	\$12 <a href="#">copay</a> for 30-day supply	Not covered	
	Tier 6: Specialty medications	50% <a href="#">coinsurance</a> after Rx <a href="#">deductible</a> for 30-day supply	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$1,500 <a href="#">copay</a> /visit	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	One <a href="#">copay</a> per surgery/case charge applies. Subject to <a href="#">copay</a> or allowed charges, whatever is less.
	Physician/surgeon fees	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$1,300 <a href="#">copay</a> per visit	\$1,300 <a href="#">copay</a> per visit	<a href="#">Copay</a> waived if admitted.
	<a href="#">Emergency medical transportation</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> for non-emergency transportation. No coverage for services without <a href="#">preauthorization</a> .
	<a href="#">Urgent care</a>	\$100 <a href="#">copay</a> per visit	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.averahealthplans.com](http://www.averahealthplans.com)\*

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$3,500 <a href="#">copay</a> per admission	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Subject to <a href="#">copay</a> or allowed charges, whichever is less. <a href="#">Preauthorization</a> required. No coverage for services without <a href="#">preauthorization</a> .
	Physician/surgeon fees	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$50 <a href="#">copay</a> per therapy visit	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Services other than therapy performed in the office or any service at a facility: 50% <a href="#">coinsurance</a> .
	Inpatient services	\$3,500 <a href="#">copay</a> per admission	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Subject to <a href="#">copay</a> or allowed charges, whichever is less. <a href="#">Preauthorization</a> required. No coverage for services without <a href="#">preauthorization</a> .
If you are pregnant	Office visits	No charge	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<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>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
	Childbirth/delivery facility services	\$3,500 <a href="#">copay</a> per admission	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.averahealthplans.com](http://www.averahealthplans.com)\*

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	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="#">copay</a> per visit	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Cardiac and pulmonary rehab services from participating providers are subject to <a href="#">coinsurance</a> and have a 36-visit maximum per <a href="#">plan</a> year.
	<a href="#">Habilitation services</a>	\$50 <a href="#">copay</a> per visit	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
If you need help recovering or have other special health needs	<a href="#">Skilled nursing care</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	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.
	<a href="#">Durable medical equipment</a>	50% <a href="#">coinsurance</a>	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 services</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	185-day limit per <a href="#">plan</a> year
If your child needs dental or eye care	Children's 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.
	Children's glasses	No charge	Not covered	One frame from the designated pediatric eyewear collection is covered. Call 1-800-877-7195 or visit <a href="#">VSP.com</a> to find a participating vision provider.
	Children's 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> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"><li>• Abortion (except when the life of the mother is endangered)</li><li>• Acupuncture</li><li>• Cosmetic surgery</li><li>• Dental care (Adult)</li></ul>	<ul style="list-style-type: none"><li>• Hearing aids</li><li>• Infertility treatment</li><li>• Long-term care</li><li>• Non-emergency care when traveling outside the United States</li></ul>	<ul style="list-style-type: none"><li>• Routine eye care (Adult)</li><li>• Routine foot care</li><li>• Weight loss program</li></ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"><li>• Bariatric surgery if <a href="#">preauthorization</a> requirements are met</li><li>• Employee Assistance Program</li></ul>	<ul style="list-style-type: none"><li>• Private-duty nursing</li></ul>	<ul style="list-style-type: none"><li>• Chiropractic care if provided by a participating provider</li></ul>

**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 Iowa Insurance Division at 1-877-955-1212. Additionally, a consumer assistance program can help you file your appeal. Contact the Iowa Bureau at 1-877-955-1212. A list of states with Consumer Assistance Programs is available at [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) and <http://cciio.cms.gov/programs/consumer/capgrants/index.html>.

### 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 the 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 1-888-322-2115.

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.

*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](#) \$0
- [Specialist copayment](#) \$150
- Hospital (facility) [copayment](#) \$3,500
- Other [coinsurance](#) 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>	\$0
<a href="#">Copayments</a>	\$4,400
<a href="#">Coinsurance</a>	\$2,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$6,460</b>

**Managing Joe's Type 2 Diabetes**

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$150
- Hospital (facility) [copayment](#) \$3,500
- Other [coinsurance](#) 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 \$5,600**

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

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,600
<a href="#">Coinsurance</a>	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,020</b>

**Mia's Simple Fracture**

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$150
- Hospital (facility) [copayment](#) \$3,500
- Other [coinsurance](#) 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 \$2,800**

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

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,400
<a href="#">Coinsurance</a>	\$600
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,000</b>

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

## 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 Customer Care team 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  
 Fax 1-800-269-8561  
 Email [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 call 1-800-368-1019 or 1-800-537-7697 (TDD). Or mail:

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

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

### Getting Help in Other Languages

- 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 (TTY: 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 1-888-322-2115 (رقم هاتف الصم والبكم 1-800-877-1113).
- ໂບດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທສ 1-888-322-2115 (TTY: 1-800-877-1113).
- ບໍລິການຊ່ວຍເຫຼືອ: ຖ້າທ່ານເວົ້າພາສາ ອື່ນ ທີ່ບໍ່ແມ່ນພາສາອັງກິດ, ການຊ່ວຍເຫຼືອດ້ານພາສາ ຈະມີພ້ອມໃຫ້ທ່ານ. ໂທສ 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 (TTY: 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.
- ພາສາອື່ນ: ຖ້າທ່ານເວົ້າພາສາ ອື່ນ ທີ່ບໍ່ແມ່ນພາສາອັງກິດ, ການຊ່ວຍເຫຼືອດ້ານພາສາ ຈະມີພ້ອມໃຫ້ທ່ານ. ໂທສ 1-888-322-2115 (TTY: 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).
- ບຼາຍກວ່າ: ເປັນສິດທິຂອງທ່ານທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອດ້ານພາສາ ຈຳນວນຈຳນວນ ທີ່ບໍ່ມີຄ່າ ຖ້າທ່ານບໍ່ເວົ້າພາສາອັງກິດ. ໂທສ 1-888-322-2115 (TTY: 1-800-877-1113).