



This 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 services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call **1-855-263-0677**. 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 www.cciio.cms.gov or call **1-855-263-0677** to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network \$1,000 person/ \$2,000 family. Out-of-Network \$2,000 person/ \$4,000 family.	Generally, you must pay all the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. In-Network <u>preventive care services</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	In-Network \$3,650 person/ \$7,300 family. Out-of-Network \$7,300 person/ \$14,600 family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.MyHealthToolkitKS.com or call 1-800-810-BLUE (2583) for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30 <u>Copay</u> / visit; <u>deductible</u> does not apply	40% <u>Coinsurance</u>	Teladoc visits are covered at No Charge.
	<u>Specialist</u> visit	\$50 <u>Copay</u> / visit; <u>deductible</u> does not apply	40% <u>Coinsurance</u>	Teladoc dermatology visits are covered with a \$30 <u>Copay</u> . Nutritional counseling is limited to 5 visits/benefit year.
	<u>Preventive care/screening/immunization</u>	No Charge	40% <u>Coinsurance</u>	See www.healthcare.gov for <u>preventive care</u> guidelines. There may be additional benefits available. See your Employer for details. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.MyHealthToolkitKS.com	Generic drugs (Retail)	\$10 Copay	Not Covered	See your Employer for benefit details.
	Generic drugs (Mail Order)	\$25 Copay	Not Covered	See your Employer for benefit details.
	Preferred brand drugs (Retail)	\$40 Copay	Not Covered	See your Employer for benefit details.
	Preferred brand drugs (Mail Order)	\$100 Copay	Not Covered	See your Employer for benefit details.
	Non-preferred brand drugs (Retail)	\$80 Copay	Not Covered	See your Employer for benefit details.
	Non-preferred brand drugs (Mail Order)	\$200 Copay	Not Covered	See your Employer for benefit details.
	<u>Specialty drugs</u>	Not Covered	Not Covered	See your Employer for benefit details.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>In-Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Varicose vein treatment is limited to \$3,000/benefit year.
	Physician/surgeon fees	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$250 <u>Copay</u> / visit then 20% <u>Coinsurance</u>	\$250 <u>Copay</u> / visit then 20% <u>Coinsurance</u>	<u>Copayment</u> will be waived if admitted.
	<u>Emergency medical transportation</u>	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	None
	<u>Urgent care</u>	\$75 <u>Copay</u> / visit; <u>deductible</u> does not apply	40% <u>Coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	<u>Pre-authorization</u> is required. Penalty for not obtaining <u>pre-authorization</u> is denial of room and board.
	Physician/surgeon fees	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Mental/behavioral health outpatient services	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Teladoc behavioral health visits and In-Network office visits are covered with a \$30 <u>Copay</u> .
	Substance use disorder outpatient services	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	
	Mental/behavioral health inpatient services	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	<u>Pre-authorization</u> is required. Penalty for not obtaining <u>pre-authorization</u> is denial of room and board.
	Substance use disorder inpatient services	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	
If you are pregnant	Office visits	\$30 <u>Copay</u> / visit; <u>deductible</u> does not apply	40% <u>Coinsurance</u>	<u>Pre-authorization</u> for facility services is required. Penalty for not obtaining <u>pre-authorization</u> is denial of room and board. Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. <u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>In-Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	Childbirth/delivery facility services	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	100 visits/benefit year. <u>Pre-authorization</u> is required. Penalty for not obtaining <u>pre-authorization</u> is denial of all charges.
	<u>Rehabilitation services</u>	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	40 visits/benefit year each for Occupational Therapy & Physical Therapy. Additional visits are required prior authorization.
	<u>Habilitation services</u>	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	40 visits/benefit year each for Occupational Therapy & Physical Therapy. Additional visits are required prior authorization.
	<u>Skilled nursing care</u>	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	120 days/benefit year. <u>Pre-authorization</u> is required. Penalty for not obtaining <u>pre-authorization</u> is denial of room and board.
	<u>Durable medical equipment</u>	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Purchase or rentals of \$5,000 or more require <u>pre-authorization</u> . Penalty for not obtaining <u>pre-authorization</u> is denial of all charges. Wigs are limited to \$500/benefit period. Hearing aids are limited to \$2,500/lifetime. Cochlear implants are limited to \$5,000/lifetime. Breast pumps and supplies are limited up to \$450/pregnancy.
	<u>Hospice services</u>	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	<u>Pre-authorization</u> is required. Penalty for not obtaining <u>pre-authorization</u> is denial of room and board for In-Network Inpatient services and denial of all charges for outpatient and all Out-of-Network services.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	See your Employer for benefit details.
	Children's glasses	Not Covered	Not Covered	See your Employer for benefit details.
	Children's dental check-up	Not Covered	Not Covered	See your Employer for benefit details.

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.)

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|-----------------------|----------------------------|------------------------|
| • Acupuncture | • Dental Care (Child) | • Routine Foot Care |
| • Bariatric Surgery | • Long-Term Care | • Weight Loss Programs |
| • Cosmetic Surgery | • Routine Eye Care (Adult) | |
| • Dental Care (Adult) | • Routine Eye Care (Child) | |

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

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| • Chiropractic Care, 20 visits/benefit year | • Infertility Treatment, \$10,000/lifetime | • Private-Duty Nursing |
| • Hearing Aids | • Non-emergency care when traveling outside the U.S. | |

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: The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa>. 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 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 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: 1-855-263-0677 or visit us at www.MyHealthToolkitKS.com, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa>.

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 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 <u>plan's</u> overall <u>deductible</u>	\$1,000
- <u>Specialist Copayment</u>	\$50
- Hospital (facility) <u>Coinsurance</u>	20%
- Other <u>Coinsurance</u>	20%

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	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,300
What isn't covered	
Limits or exclusions	\$70
The total Peg would pay is	\$3,370

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

- The <u>plan's</u> overall <u>deductible</u>	\$1,000
- <u>Specialist Copayment</u>	\$50
- Hospital (facility) <u>Coinsurance</u>	20%
- Other <u>Coinsurance</u>	20%

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	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$4,300
The total Joe would pay is	\$4,700

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

- The <u>plan's</u> overall <u>deductible</u>	\$1,000
- <u>Specialist Copayment</u>	\$50
- Hospital (facility) <u>Coinsurance</u>	20%
- Other <u>Coinsurance</u>	20%

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
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$700
<u>Coinsurance</u>	\$100
What isn't covered	
Limits or exclusions	\$100
The total Mia would pay is	\$1,810

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-855-263-0677.

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

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-832-9686 (TTY: 711) or speak to your provider.

Espanol: ATENCION: Si habla espaniol, tiene a su disposici6n servicios gratuitos de asistencia lingufstica. Tambien estan disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar informaci6n en formatos accesibles. Llame al 1-844-396-0183 (TTY: 711) o hable con su proveedor. (Spanish)

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Tagalog: PAALALA: Kung nagsasalita ka ng Tagalog, available ang mga libreng serbisyo ng tulong sa wika para sa iyo. Available rin nang walang bayad ang mga naaangkop na auxiliary na tulong at serbisyo para magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-844-389-4839 (TTY: 711) o makipag-usap sa iyong provider. (Tagalog)

Portugues do Brasil: ATEN<:::A.O: Se voce fala portugues, ha servi9os gratuitos de assistencia linguistica disponiveis para voce. Assistencia e servi9os auxiliares pr6prios para fornecer informa96es em formatos acessiveis tambem estao disponiveis gratuitamente. Ligue para 1-844-396-0182 (TIY: 711) ou fale com seu provedor. (Portuguese)

Fran9ais : NOTE : Si vous parlez fran9ais, des services gratuits d'assistance linguistique sont it votre disposition. Des aides et des services auxiliaires appropries pouvant fournir des informations dans des formats accessibles sont egalement disponibles gratuitement. Appelez le 1-844-396-0190 (TTY: 711) ou adressez-vous it votre prestataire. (French)

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Deutsch: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzen Dienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie unter 1-844-396-0191 (TTY: 711) an oder sprechen Sie mit Iluem Anbieter. (German)

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Dine SHOOH: Dine bee yanilti'gogo, saad bee ana'awo' bee aka'anida'awo'it'aajjik'eh na h61Q. Bee ahil hane'go bee nida'anishi t'aa akodaat'ehigii d66 bee aka'anida'wo'i ako bee baa hane'i bee hadadilyaa bich'i' ahoot'i'igii *ei* t'aa jjik'eh h61Q. Kohji' 1-844-516-6328 (TTY: 711) hodiilnih doodago nika'analwo'i bich'i' hanidziih. (Navajo)

Kiswahili MAKINIKA: lkiwa wewe huzungumza Kiswahili, msaada na huduma za lugha bila malipo unapatikana kwako. Vifaa vya usaidizi vinavyofaa na huduma bila malipo iii kutoa taarifa katika mifumo inayofikiwa pia inapatikana bila malipo. Piga simu 1-844-465-1726 (TTY: 711) au zungumza na mtoa huduma wako. (Swahili)

i'.atJC<' atJr'u!rtf'- i'.atJC<' l'OLL 'i74- hl!7= l'!l;>',ll> _f:~fj+- i'.7C1"7l\~t m, _e<t>CnCl'iP;r,Ci: /Jll(□), n+.et-n 'P(ilt i\atq,({l +In_ W'r +r,T;atJ<'!, 'l'7tiPf l,'l' i'.7C1"71'l~H l,,".11_1.) m, _e,7<' {~:~: nMh 9?'1'(1-844-465-1592 (TTY: 711) £,£(!).i\~ CDE,9" i'.7C1"7l\~t i'.<|>~l_ 'iP", l'!"J4~: (Amharic)

Soomaali FIIRO GAAR AH: Haddaad ku hadasho Soomaali, adeegyo kaalmada luuqadda ah oo bilaash ah ayaad heli kartaa. Qalab caawinaad iyo adeegyo oo habboon si loogu bixiyo macluumaadka qaabab la adeegsan karo ayaa sidoo kale bilaa lacag heli karaa. Wac 1-844-465-1724 (TTY: 711) ama la hadal bixiyahaaga. (Somali)

ILOCANO PANANGIKASO: No agsaasaoka iti Ilocano, magun-odmo dagiti libre a serbisio ti tulong iti pagsasao. Libre met laeng a magun-odan dagiti maitutop a katulongan ken serbisio a mangipaay iti impormasion kadagiti ma-aksas a pormat. Awagan ti 1-800-832-9686 (TTY: 711) wenna makisarita iti mangipapaay kenka. (Ilocano)

□mcr̥m̥: □c1q1\$0-!%-*11IITfifi cii□i>vlt□□□-lc1q1\$cfii □c;.=r:□IMi □□□□□iY0, Iq̣q̣il<1-≤i□i□i□i□i□□□o-1-1.3q<Jcfc1 □□□qc;...rc;f.=t: □IMi □iY0, I 1-844-465-1722 (TTY: 711)m

q;).,□ 3TTf04T□, TT□ (Nepali)

ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sano inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama 1'1-844-396-0184 (TTY: 711) o parla con ii tuo fornitore. (Italian)

<IT□"fT

□5T□.:□'51T91R<IT□'1T<W'R□'51T□□f<H1Sfi.'1' □ 1In' □ □ □ □ □ I\5IICSi:5iC□i2Ii ¾>i1iillic'G□□□□□□□□5'1'5T □ □ □ '3 N-iS/C<i□ □ □ □ □ I

1-844-465-1713 (TTY: 711) □<P"□f□Gf□'51T□<'1'111-1,q>□i1:>iTC□□□□I (Bengali)

Kreyol Ayisyen ATANSYON: Si w pale Kreyol Ayisyen, gen sevis ed aladispozisyon w gratis pou lang au pale a. Ed ak sevis siplemante apwopriye pou bay enfomasyon nan foma aksesib yo disponib gratis tau. Rele nan 1-844-465-1715 (TTY: 711) oswa pale avek founise w la. (Haitian Creole)

POLSKI UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach Sq równiei dostpne bezpłatnie. Zadzwon pod numer 1-844-396-0186 (TTY: 711) lub porozmawiaj ze swoim dostawcq. (Polish)

□e.x>m

<0"jQ"□O: □O) □e.x>m jy>□□□' □W e.--w□□ (O□O}) □je...,) @OQ)cJ"e)Y!f (.:g-Qe.J"ill). mY'SJ□ 00})Ke.) □CT"Je':Je.)6' r0jy>w"CJ"□:} @ocSoe>CY□\$ □M (O□O})□ r0□O)J"e.)) □j.)60}).) □je...,) W'G:9' e.--w□OIT' @OCT!cJ"b:J6 e.-oe.Y"m:>. 1-800-832-9686 (TTY: 711)§ S"e) 00})O□ eJCY' □ L&r"□OO□ jy>□oo□. (Telugu)

Lus Hmoob
LUS CEEV TSHWJ XEEB: Yog hais tias koj hais Lus Hmoob muaj cov kev pab cuam txhais lus pub dawb rau koj. Cov kev pab thiab cov kev pab cuam ntxiv uas tsim nyog txhawm rau muab lus qhia paub ua cov horn ntaub ntawv uas tuaj yeem nkag cuag tau rau los kuj yeej tseem muaj pab dawb tsis xam tus nqi dab tsi ib yam nkaus. Hu rau 1-844-465-1717 (TTY: 711) los sis sib tham nrog koj tus kws muab kev saib xyuas kho mob. (Hmong)

□
n:))fTo JW:□□-□ wc1,3im m!t□ □ □ □ □ □ □
)13□□□-MJ□□ u o11844-465-1723
(TTY: 711) '3c(Tgc@tP))fiIR□<W,cJIBc@I (Punjabi)

171nnt§I□HWnG\;)□nt:11Ai LUwstu□nstmw l'flhflf?JU11nn1c1t\.:l\$Wffinni"Inf'intj:jii'IHi SnJLHiU□n□ C; \$W s□tn1nn1c1t't:1rm::l1ffi11i'IW□nJH1HJ !;')□ffil\:'!runf'iHi SffiHSLH8tt:1ruH1ugrutLuu.;1we; s
AH1G1nC1stt:11Wi"Inf'int□Ci□tt:11□ tUTi□InJl]tsi 1-844-465-1721 (TTY: 711) ystmwtsiffiS□n1:'!rutn1f11Ut\J□n□ (Khmer)

oy., o1t>,>,\,.) L, L, n□ <Yw (711 !:'<:li.;J;:) 1-844-398-6233)....& I., _;it4s-- oy,y; uK,l..))_kd, •(Y'y.u,l J,L!<SIA,yIL, _w w□)Lb\ "-'U <SIY. '-,ww..i... "4- wl...wi. J lA,□□ J_ Jv J) W (Y'y.u.,l _w ul,j cs'□ uK,l..) wl...wi. ""As'□i.r'..Jt_.; },I :<4y (Farsi). □ □

(Urdu) -u,J, wl, C •□rII.J C:?-i L, u,_f, JS√:.(1-844-465-1725 TIY: 711)-u:li yi_;;....., wl.o<#. c;t....., JJI ob.\ uJ1,,, '-,Wu.. d cf, c: ?J. rII.J wt._,1...oY..A □...Jt; i:s'w..J J,L! .U:t/y l;.,uu c;t....., c,Su□I<s'l.u]wl.o d cf;'-; -l y 'U:ff c"Y. _o)'71.J,l :u,o□Y

ill'T'□
D'i) DII77 7I7I□ 1-833-584-1829 (TTY: 711) j917 .?□,m□j19 "79 7Ji77i711□ 7'1□ jI7I7T jDNI)7□9 I)J'7D'7DI" j'N i7""□1)7N9I□ j7I7Diil'm" OI70'117I70 1I□ '17: j '7'7Ij)1N I)J'-0□9 -I" N 7N9 7Ji77i711□ jI7I7T OI70'117I70 '17: j 7N79Iil i7DO'Tm□, iil'I'□ DII77 7'□ J'I□ 7D (Yiddish) .7I71"11□79 7I7"N

Deutsch
WICHDICH: Wann du Deutsch schwetzscht, kenne mer dich Schprooch-Hilf griege. Mir kenne dich aa diffemti Sadde Hilf griege, wasewwer as brauchscht fer Information griege, unni as es dich ennich eppes koschde zellt. Call 1-833-584-1829 (TTY: 711) uff odder schwetz mit dei Provider. (Pennsylvania Dutch)

Eil.il.r,vtKa
nPOIOXH: Eav pLAaTE Eil.il.r,vtKa, urrapxouv lita8!'mpuE, liwpEav urrr,prniE, urroaT□PL□fl, aTr, auyKEKptμ':vr, y>..waaa. lhmi8EvTm liwpEav Kmai\il.r;.l..a por,8□pam Km urrr,prniE, ym rrapox□ m>..r,poφoptwv a£ rpoapamμE, μopδ!':..
KaMaTE m 1-844-465-1714 (TTY: 711) □ arrEU8uv8EITE arnv rrapox6 aa,. (Greek)

Oromoo
Afaan Oromoo HUBACHIISA: Yoo Afaan Oromoo dubbattan ta'e, tajaajilloota gargaarsa afaanii bilisaan isiniif ni kennama. Gargaarsoonni fi tajaajilloonni sirrii ta'an namoota dhagahuufi arguun isaan rakkisuuf odeeffannoo dhangii dhaqqabamaa ta'een kennuunis bilisaan niargamu. Gara 1-800-832-9686 (TTY: 711) tti bilbilaa yookiin qopheessaa keessan haasofsiisaa. (Orama)

Gagana Samoa
FAAALIGA: Afai e te tautala i le Gagana Samoa, o loo maua fua auaunaga lagolago mo gagana. 0 le a maua fua fo'i mea faalogo, isi faiga tau fesoasoani ma auaunaga talafeagai e tuuina mai ai faamatalaga i auala faigofie ona maua. Viii le 1-800-832-9686 (TTY: 711) pe talanoa i lau fai auaunaga. (Samoan)