

 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 877-838-4949 or visit us at [www.healthpartners.com](http://www.healthpartners.com). 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 877-838-4949 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	In-network: \$6,350 Individual/ \$12,700 Family Out-of-network: \$20,000 Individual/ \$40,000 Family	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, some preventive care services are covered before you meet your deductible.	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 preventive services 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>	There are no other specific <a href="#">deductibles</a> .	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	In-network medical/pharmacy: \$9,450 Individual/\$18,900 Family There is no out-of-network <a href="#">out-of-pocket limit</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.

Important Questions	Answers	Why This Matters:
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premium</a> , balance-billed charges (unless <a href="#">balanced billing</a> is prohibited), and health care this <a href="#">plan</a> doesn't 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.healthpartners.com/robin/selectind">www.healthpartners.com/robin/selectind</a> or call 1-877-838-4949 for a list of <a href="#">in-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 plan's <a href="#">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 <a href="#">provider's</a> 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 in-network <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, and Other Important Information
		<a href="#">Network Provider</a> (You will pay the least)	<a href="#">Out-of-Network Provider</a> (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	Primary Office Visit: \$30 <a href="#">copay</a> for the first four visits and 30% <a href="#">coinsurance</a> thereafter Convenience Care: \$15 <a href="#">copay</a> for the first four visits and 30% <a href="#">coinsurance</a> thereafter Virtuwell: No charge	Primary Office Visit: 50% <a href="#">coinsurance</a> Convenience Care: 50% <a href="#">coinsurance</a>	Each family member's first four combined office or urgent care visits are a copay. Other services like lab, x-rays, MRI/CT scans are covered at deductible/coinsurance.
	<a href="#">Specialist</a> visit	\$30 <a href="#">copay</a> for the first four visits and 30% <a href="#">coinsurance</a> thereafter	50% <a href="#">coinsurance</a>	Each family member's first four combined office or urgent care visits are a copay. Other services like lab, x-rays, MRI/CT scans are covered at deductible/coinsurance.
	<a href="#">Preventive care/screening/immunization</a>	No charge	50% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, and Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				needed 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)	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://healthpartners.com/preferredrx">healthpartners.com/preferredrx</a>	Generic drugs	<a href="#">Formulary</a> Low Cost: \$5 <a href="#">copay</a> /Per Prescription, <a href="#">Deductible</a> does not apply at retail, \$15 <a href="#">copay</a> /per 90 day supply, <a href="#">Deductible</a> does not apply at mail <a href="#">Formulary</a> High Cost: \$25 <a href="#">copay</a> /Per Prescription, <a href="#">Deductible</a> does not apply at retail, \$75 <a href="#">copay</a> /per 90 day supply, <a href="#">Deductible</a> does not apply at mail <a href="#">Non-formulary</a> : 50% <a href="#">coinsurance</a>	<a href="#">Formulary</a> : 50% <a href="#">coinsurance</a> at retail, mail not covered <a href="#">Non-formulary</a> : 50% <a href="#">coinsurance</a> at retail, mail not covered	30 day supply retail / 90 day supply mail order. Formulary insulin covered with no member cost-sharing after a \$25 benefit cap per prescription per month.
	Preferred brand drugs	30% <a href="#">coinsurance</a> at retail, 30% <a href="#">coinsurance</a> at mail	50% <a href="#">coinsurance</a> at retail, mail not covered	
	Non-preferred brand drugs	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> at retail, mail not covered	
	<a href="#">Specialty drugs</a>	50% <a href="#">coinsurance</a>	Not covered	Specialty drugs are limited to drugs on the specialty drug list and must be obtained from a designated vendor.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, and Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Out-of-network services apply to the in-network deductible.
	<a href="#">Emergency medical transportation</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Out-of-network services apply to the in-network deductible.
	<a href="#">Urgent care</a>	\$30 <a href="#">copay</a> for the first four visits and 30% <a href="#">coinsurance</a> thereafter	50% <a href="#">coinsurance</a>	Each family member's first four combined office or urgent care visits are a copay. Other services like lab, x-rays, MRI/CT scans are covered at deductible/coinsurance.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
If you need mental health, behavioral health, or substance abuse needs	Outpatient services	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	Inpatient services	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
If you are pregnant	Office visits	No charge	50% <a href="#">coinsurance</a>	Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	Childbirth/delivery facility services	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	30% <a href="#">coinsurance</a>	Not covered	60 visits per calendar year
	<a href="#">Rehabilitation services</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Limited to 20 visits each per calendar year
	<a href="#">Habilitation services</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Limited to 20 visits each per calendar year
	<a href="#">Skilled nursing care</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	30 days per confinement
	<a href="#">Durable medical equipment</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, and Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<a href="#">Hospice services</a>	30% <a href="#">coinsurance</a>	Not covered	Respite care is limited to 5 days per episode and respite care and continuous care combined are limited to 30 days per episode .
If your child needs dental or eye care	Children's eye exam	No charge	50% <a href="#">coinsurance</a>	None
	Children's glasses	30% <a href="#">coinsurance</a>	Not covered	Limited to one pair of eyeglasses (lenses and frames) or one pair of contact lenses per calendar year.
	Children's dental check-up	Not covered	Not covered	None

#### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric surgery</li> <li>• Cosmetic surgery</li> <li>• Dental care</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Private-duty nursing</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care (Adult)</li> <li>• Routine foot care</li> <li>• Termination of pregnancy, except in cases of rape, incest, or danger to the life of the mother.</li> <li>• Weight loss programs</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>• Chiropractic care</li> <li>• Hearing aids</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: Your plan at 1-800-883-2177, or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov) or the Wisconsin Office of the Commissioner of Insurance at 608-266-0103 / 1-800-236-8517. 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: Your [plan](#) at 1-800-883-2177 or the Wisconsin Office of the Commissioner of Insurance at 608-266-0103 / 1-800-236-8517. Additionally, a consumer assistance program can help you file your [appeal](#). Contact the Wisconsin Office of the Commissioner of Insurance at 608-266-0103 / 1-800-236-8517.

**Does this [plan](#) provide [Minimum Essential Coverage](#)? Yes.**

[Minimum Essential Coverage](#) generally includes [plan](#), [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](#)? Not Applicable.**

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 1-877-838-4949.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-838-4949.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-877-838-4949.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-838-4949.

————— *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](#) \$6,350
- [Specialist copay](#) \$30
- Hospital (facility) 30%
- [coinsurance](#)
- Other [coinsurance](#) 30%

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$6,350
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,800
<i>What isn't covered</i>	
Limits or exclusions	\$70
<b>The total Peg would pay is</b>	<b>\$8,220</b>

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

- The [plan's](#) overall [deductible](#) \$6,350
- [Specialist copay](#) \$30
- Hospital (facility) 30%
- [coinsurance](#)
- Other [coinsurance](#) 30%

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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$1,600
<a href="#">Copayments</a>	\$800
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,420</b>

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

- The [plan's](#) overall [deductible](#) \$6,350
- [Specialist copay](#) \$30
- Hospital (facility) 30%
- [coinsurance](#)
- Other [coinsurance](#) 30%

This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$2,800
<a href="#">Copayments</a>	\$40
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>



## Statement of Nondiscrimination for Health Plan Members

### Our Responsibilities:

We follow Federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability or sex. We do not exclude people or treat them differently because of their race, color, national origin, age, disability or sex, including gender identity and sexual orientation.

- We help people with disabilities to communicate with us. This help is free. It includes:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio and accessible electronic formats
- We provide services for people who do not speak English or who are not comfortable speaking English. These services are free. They include:
  - Qualified interpreters
  - Information written in other languages

### For Language or Communication Help:

Call 1-800-883-2177 if you need language or other communication help. (TTY: 711)

### If you have questions about our non-discrimination policy:

Contact the Civil Rights Coordinator at 1-844-363-8732 or [integrityandcompliance@healthpartners.com](mailto:integrityandcompliance@healthpartners.com).

### To File a Grievance:

If you believe that we have not provided these services or have discriminated against you because of your race, color, national origin, age, disability or sex, you can file a grievance by contacting the Civil Rights Coordinator at 1-844-363-8732, [integrityandcompliance@healthpartners.com](mailto:integrityandcompliance@healthpartners.com) or Civil Rights Coordinator, Office of Integrity and Compliance, MS 21 103K, 8170 33rd Ave. S., Bloomington, MN 55425.

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:

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

<p>Español (<i>Spanish</i>) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-883-2177. (TTY: 711)</p>	<p>ພາສາລາວ (<i>Laotian</i>) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ຕະມັນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-883-2177. (TTY: 711)</p>
<p>Hmoob (<i>Hmong</i>) LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-883-2177. (TTY: 711)</p>	<p>Deutsch (<i>German</i>) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-883-2177. (TTY: 711)</p>
<p>Tiếng Việt (<i>Vietnamese</i>) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-883-2177. (TTY: 711)</p>	<p>العربية (<i>Arabic</i>) ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-883-2177 (رقم هاتف الصم والبكم: 711)</p>
<p>繁體中文 (<i>Chinese</i>) 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 1-800-883-2177. (TTY: 711)</p>	<p>Français (<i>French</i>) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-883-2177. (ATS: 711)</p>
<p>Русский (<i>Russian</i>) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-883-2177. (телетайп: 711)</p>	<p>한국어 (<i>Korean</i>) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-883-2177. (TTY: 711)</p>
<p>Af Soomaali (<i>Somali</i>) OGAYSIIS: Haddii aad ku hadasho afka soomaaliga, Waxaa kuu diyaar ah caawimaad xagga luqadda ah oo bilaash ah. Fadlan soo wac 1-800-883-2177. (TTY: 711)</p>	<p>Tagalog (<i>Tagalog</i>) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-883-2177. (TTY: 711)</p>



<p>Oromiffa (<i>Cushite [Oromo]</i>)          XIYYEEFFANNA: Afaan dubbattu Oromiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-883-2177. (TTY: 711)</p>	<p>Italiano (<i>Italian</i>)          ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-883-2177. (TTY: 711)</p>
<p>አማርኛ (<i>Amharic</i>)          ማህበራዊ ምክንያቶችን ተቀባይ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገለግሉት ተዘጋጅተዋል። ወደ ሚኒሶታፊ ቁጥር ይደውሉ 1-800-883-2177. (መስማት ለተሳናቸው: 711)</p>	<p>ภาษาไทย (<i>Thai</i>)          หมายเหตุ: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-883-2177. (TTY: 711)</p>
<p>unD (<i>Karen</i>)          ဝံသုဉ်ဝံသး- နမူကတိက တညီ ကျိာ်အယိ, နမူနာ ကျိာ်အတိမာစာလော တလက်တုဉ်လက်စွာ နိတမံတုဉ်သုနုဉ်လိာ်. ကိ: 1-800-883-2177. (TTY: 711)</p>	<p>ελληνικά (<i>Greek</i>)          ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-883-2177. (TTY: 711)</p>
<p>ខ្មែរ (<i>Mon-Khmer, Cambodian</i>)          ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 1-800-883-2177. (TTY: 711)</p>	<p>Diné Bizaad (<i>Navajo</i>)          Dít baa akó nínfízin: Dít saad bee yánífti'go <b>Diné Bizaad</b>, saad bee áká'ánída'áwo'déé', t'áá jiiik'eh, éí ná hóló, kójjí' hódíílnih 1-800-883-2177. (TTY: 711)</p>
<p>Deutsch (<i>Pennsylvanian Dutch</i>)          Wann du Deutsch schwetzsch, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-883-2177. (TTY: 711)</p>	<p>Ikirundi (<i>Bantu – Kirundi</i>)          ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-883-2177. (TTY: 711)</p>
<p>Polski (<i>Polish</i>)          UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-883-2177. (TTY: 711)</p>	<p>Kiswahili (<i>Swahili</i>)          KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-800-883-2177. (TTY: 711)</p>
<p>हिंदी (<i>Hindi</i>)          ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-883-2177. (TTY: 711)</p>	<p>日本語 (<i>Japanese</i>)          注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-883-2177 (TTY: 711) まで、お電話にてご連絡ください。</p>
<p>Shqip (<i>Albanian</i>)          KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-883-2177. (TTY: 711)</p>	<p>नेपाली (<i>Nepali</i>)          ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू नि:शुल्क रूपमा उपलब्ध छ। फोन गर्नुहोस् 1-800-883-2177 (टिडिवाइ: 711)</p>
<p>Srpsko-hrvatski (<i>Serbo-Croatian</i>)          OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-883-2177. (TTY: 711)</p>	<p>Norsk (<i>Norwegian</i>)          MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-800-883-2177. (TTY: 711)</p>
<p>ગુજરાતી (<i>Gujarati</i>)          સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-883-2177. (TTY: 711)</p>	<p>Adamawa (<i>Fulfulde, Sudanic</i>)          MAANDO: To a waawi Adamawa, e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-800-883-2177. (TTY: 711)</p>
<p>اُردُو (<i>Urdu</i>)          خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں 1-800-883-2177. (TTY: 711)</p>	<p>Українська (<i>Ukranian</i>)          УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-883-2177. (телетайп: 711)</p>