




STATE OF SOUTH DAKOTA ROOSEVELT



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 [www.wellmark.com](http://www.wellmark.com) or call 1-800-846-9183. 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 1-800-846-9183 to request a copy.

Important Questions	Answers	Why this Matters:
<b>What is the overall <u>deductible</u>?</b>	\$0 person .	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> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	No. This <u>plan</u> has no <u>deductibles</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 certain <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 <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No. There are no other specific <u>deductibles</u> .	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	Health In- <u>Network</u> : <b>\$5,000</b> person/ <b>\$10,000</b> family . Health Out-Of- <u>Network</u> : <b>\$9,500</b> person/ <b>\$19,000</b> family . Drug Card: <b>\$5,000</b> person/ <b>\$10,000</b> family . The In- <u>Network</u> health and drug card <u>out-of-pocket</u> maximum amounts accumulate together.	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.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	Premiums, <u>balance-billed charges</u> , 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> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.wellmark.com">www.wellmark.com</a> or call 1-800-846-9183 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 out-of- <u>network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an out-of- <u>network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

Important Questions	Answers	Why this Matters:
Do you need a <u>referral</u> to see a <u>specialist</u> ?	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. More than one copay may apply for a service.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$30 <u>copay</u> per <u>provider</u> per date of service	\$60 <u>copay</u> per <u>provider</u> per date of service	Primary Care Practitioners (PCP) are defined as General and Family Practice, Internal Medicine, OB/GYN, Pediatricians, Nurse Practitioners, Certified Nurse Midwives and PAs. Office <u>copays</u> apply to any covered services received in each office visit. Doctor on Demand contracted telehealth services are covered.
	<u>Specialist</u> visit	\$60 <u>copay</u> per <u>provider</u> per date of service \$60 <u>copay</u> for <u>Specialty drugs</u> covered under medical when billed with office location, \$2,500 when billed as other than office	\$120 <u>copay</u> per <u>provider</u> per date of service \$120 <u>copay</u> for <u>Specialty drugs</u> covered under medical when billed with office location, \$5,000 when billed as other than office	Applies to Non-PCP <u>providers</u> . \$30 <u>copay</u> per <u>provider</u> per date of service for in- <u>network</u> chiropractic services. Hearing exams are covered according to ACA guidelines.
	<u>Preventive care/screening/immunization</u>	No charge	<u>Copay</u> applies based on type of service which may be described elsewhere in the SBC	One preventive exam and one mammogram per benefit year. Well-child care is covered to age 7. Cholesterol, Glucose tests (not including A1c), and Venipuncture are covered when billed as preventive, waive cost share. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-846-9183.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have a test	Diagnostic test (x-ray, blood work)	\$30 copay per provider per date of service	\$60 copay per provider per date of service	For a test in a provider's office or clinic, your cost is included in the cost-share listed above.
	Imaging (CT/PET scans, MRIs)	\$500 copay per provider per date of service	\$500 copay per provider per date of service	-----None-----
If you need drugs to treat your illness or condition  More information about <b>prescription drug coverage</b> is at <a href="http://www.wellmark.com/prescriptions">www.wellmark.com/prescriptions</a> .	Tier 1	\$25 copay per prescription	\$25 copay per prescription	Drugs listed on Wellmark's Blue Rx Value Plus Drug List are covered. Drugs not on this Drug List are not covered. You pay the discounted cost of your prescription drugs until your in-network deductible is met. For out-of-network prescription drugs, you may be balance billed. 1 copay for 30-day supply. 2.5 copays for 90-day supply (Retail and Mail order maintenance). Waive cost share for Prenatal Vitamins. Specialty drugs are covered only when obtained through the Specialty Pharmacy Program. Your plan includes coverage for certain specialty drugs through PrudentRx. If you choose to opt into the PrudentRx program, your deductible and coinsurance will be waived for drugs listed on the PrudentRx drug list. Information about the PrudentRx program can be found in your plan document in these sections: What You Pay, Details-Covered and Not Covered, Choosing a Provider, Factors Affecting What You Pay, and the Glossary. See <a href="http://wellmark.com/prescriptions">wellmark.com/prescriptions</a> for information about drugs and drug quantities that require prior authorization by Wellmark to be covered by your plan.
	Tier 2	\$65 copay per prescription	\$65 copay per prescription	
	Tier 3	\$150 copay per prescription	\$150 copay per prescription	
	Specialty drugs	Generic/Preferred: \$300 copay per prescription Non-Preferred: \$450 copay per prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$2,500 copay per provider per date of service	\$5,000 copay per provider per date of service	Outpatient copays apply to covered services for each facility and physician(s) separately.
	Physician/surgeon fees	Combined with facility copay	Combined with facility copay	Outpatient copays apply to covered services for each facility and physician(s) separately.

For more information about limitations and exceptions, see your [plan](#) document or call Wellmark at 1-800-846-9183.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	<u>Emergency room care</u>	\$500 <u>copay</u> per visit for facility only	\$500 <u>copay</u> per visit for facility only	For <u>emergency medical conditions</u> treated out-of-network, it is likely you may not be balance billed pursuant to the federal rules developed for implementation of the No Surprises Act.
	<u>Emergency medical transportation</u>	<u>Copays per provider per date of service:</u> Ground: \$500 Air: \$3,500	<u>Copays per provider per date of service:</u> Ground: \$500 Air: \$7,000	For covered non-emergent situations, out-of-network ground ambulance services are NOT reimbursed at the in-network level. The member may be balance billed for any out-of-network service as established under the rules developed for implementation of the No Surprises Act.
	<u>Urgent care</u>	\$30 <u>copay</u> per <u>provider</u> per date of service	\$60 <u>copay</u> per <u>provider</u> per date of service	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	\$3,500 <u>copay</u> per admission	\$7,000 <u>copay</u> per admission	-----None-----
	<u>Physician/surgeon fees</u>	Combined with facility <u>copay</u>	Combined with facility <u>copay</u>	-----None-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	<u>Copays per provider per date of service:</u> Office: \$30 Outpatient: \$2,500	<u>Copays per provider per date of service:</u> Office: \$60 Outpatient: \$5,000	Facility <u>copay</u> applies per <u>provider</u> per date of service for facility only.
	Inpatient services	\$3,500 <u>copay</u> per admission	\$7,000 <u>copay</u> per admission	-----None-----

For more information about limitations and exceptions, see your [plan](#) document or call Wellmark at 1-800-846-9183.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you are pregnant	Office visits	\$30 <u>copay</u> per <u>provider</u> per date of service	\$60 <u>copay</u> per <u>provider</u> per date of service	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for <u>preventive services</u> . For any <u>in-network</u> services that fall outside of routine obstetric care, the office visit benefits shown above may apply.
	Childbirth/delivery professional services	Combined with inpatient services	Combined with inpatient services	Benefits shown reflect OB/GYN practitioner services which are typically globally billed at time of delivery for pre-natal, post-natal and delivery services. <u>Copay</u> is waived for healthy newborn.
	Childbirth/delivery facility services	\$3,500 <u>copay</u> per <u>provider</u> per date of service	\$7,000 <u>copay</u> per <u>provider</u> per date of service	Inpatient <u>copays</u> apply to covered services for facility and physician(s) combined.

For more information about limitations and exceptions, see your [plan](#) document or call Wellmark at 1-800-846-9183.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	\$60 <u>copay</u> per <u>provider</u> per date of service	\$120 <u>copay</u> per <u>provider</u> per date of service	\$2,500 in-network/\$5,000 out-of-network <u>copay</u> applies to home infusion therapies. <u>Home health care copays</u> apply per <u>provider</u> per date of service.
	<u>Rehabilitation services</u>	<u>Copays per provider per date of service:</u> Office: \$30 Outpatient: \$60	<u>Copays per provider per date of service:</u> Office: \$60 Outpatient: \$120	Office <u>copays</u> apply per <u>provider</u> per date of service and to any covered services received in each office visit. Outpatient <u>copays</u> apply per <u>provider</u> per date of service and are applied to covered services for each physician or facility separately.
	<u>Habilitation services</u>	<u>Copays per provider per date of service:</u> Office: \$30 Outpatient: \$60	<u>Copays per provider per date of service:</u> Office: \$60 Outpatient: \$120	Office <u>copays</u> apply per <u>provider</u> per date of service and to any covered services received in each office visit. Outpatient <u>copays</u> apply per <u>provider</u> per date of service and are applied to covered services for each physician or facility separately.
	<u>Skilled nursing care</u>	\$3,500 <u>copay</u> per <u>provider</u> per date of service	\$7,000 <u>copay</u> per <u>provider</u> per date of service	Inpatient <u>copays</u> apply to covered services for facility and physician(s) combined.
	<u>Durable medical equipment</u>	\$60 <u>copay</u> per <u>provider</u> per date of service	\$120 <u>copay</u> per <u>provider</u> per date of service	-----None-----
	<u>Hospice services</u>	\$3,500 <u>copay</u> per <u>provider</u> per date of service	\$7,000 <u>copay</u> per <u>provider</u> per date of service	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	Not covered	One routine vision exam per benefit year.
	Children's glasses	Not covered	Not covered	-----None-----
	Children's dental check-up	Not covered	Not covered	-----None-----

For more information about limitations and exceptions, see your [plan](#) document or call Wellmark at 1-800-846-9183.



## 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.)

- Cosmetic surgery
- Custodial care - in home or facility
- Dental care - Adult
- Dental check-up
- Extended home skilled nursing
- Glasses
- Long-term care
- Routine foot care
- Some pharmacy drugs are not covered
- Weight loss programs

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

- Acupuncture (Limited to 12 visits per benefit year)
- Applied Behavior Analysis therapy
- Bariatric surgery
- Chiropractic care
- Hearing aids (Covered to age 9)
- Infertility treatment (excludes some services)
- Most coverage provided outside the U.S.
- Private-duty nursing - short term intermittent home skilled nursing
- Routine eye care - Adult (One vision exam per benefit year.)

**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 U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). 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, you can contact: Wellmark at 1-800-846-9183 or Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

### 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.

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

**Wellmark Blue Cross and Blue Shield of South Dakota is an independent licensee of the Blue Cross and Blue Shield Association.**

*This contains only a partial description of the benefits, limitations, exclusions and other provisions of the health care plan. It is not a contract or policy. It is a general overview only. It does not provide all the details of coverage, including benefits, exclusions, and policy limitations. In the event there are discrepancies between this document and the Coverage Manual, Certificate, or Policy, the terms and conditions of the Coverage Manual, Certificate, or Policy will govern.*

## 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 <u>deductible</u>	\$0
■ PCP <u>copayment</u>	\$30
■ Hospital(facility) <u>copayment</u>	\$3,500
■ Other not covered	Not Covered

**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:**

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$5,000
<u>Coinsurance</u>	\$0
What isn't covered	
<b>Limits or exclusions</b>	<b>\$60</b>
<b>The total Peg would pay is</b>	<b>\$5,060</b>

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

■ The plan's overall <u>deductible</u>	\$0
■ <u>Specialist</u> <u>copayment</u>	\$60
■ Hospital(facility) <u>copayment</u>	\$2,500
■ Other <u>copayment</u>	\$60

**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:**

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$2,000
<u>Coinsurance</u>	\$0
What isn't covered	
<b>Limits or exclusions</b>	<b>\$20</b>
<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 <u>deductible</u>	\$0
■ <u>Specialist</u> <u>copayment</u>	\$60
■ Hospital(facility) <u>copayment</u>	\$500
■ Other <u>copayment</u>	\$60

**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:**

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,400
<u>Coinsurance</u>	\$0
What isn't covered	
<b>Limits or exclusions</b>	<b>\$0</b>
<b>The total Mia would pay is</b>	<b>\$1,400</b>

The amounts shown in the maternity claim example above are based on amounts using a single per person deductible. Some plans may actually apply a two-person or family deductible to maternity services for the mother and newborn baby.

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





# Wellmark Language Assistance

### Discrimination is against the law

Wellmark Blue Cross and Blue Shield complies with applicable state and federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

### Wellmark provides:

- Free aids and services to people with disabilities so they may communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

**You have the right to get this information and help in your language for free. If you need these services, call 800-524-9242.**

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Comuníquese al 800-524-9242 o al (TTY: 888-781-4262).

Geb Acht: Wann du Deutsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

注意：如果您说普通话，我们可免费为您提供语言协助服务。请拨打 800-524-9242 或（听障专线：888-781-4262）。

โปรดทราบ: หากคุณพูด ไทย เรามีบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่คิดค่าใช้จ่าย ติดต่อ 800-524-9242 หรือ (TTY: 888-781-4262)

CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Xin hãy liên hệ 800-524-9242 hoặc (TTY: 888-781-4262).

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Makipag-ugnayan sa 800-524-9242 o (TTY: 888-781-4262).

NAPOMENA: Ako govorite hrvatski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte 800-524-9242 ili (tekstualni telefon za osobe oštećena sluha: 888-781-4262).

တၢ်ဒုးသ့ၣ်ညါ-န့ၣ်ကတိၢ်ကေညါကိၣ်, ကိၣ်တၢ်မၤစၢတၢ်ဖဲတၢ်မၤတဖၣ်, လၢတဘၣ်လၢတဘၣ်လၢ, ဆိၣ်လၢန့ၣ်လိၤဆဲးကိၣ်ဆူ ၈၀၀-၅၂၄-၉၂၄ န့ၣ်တဖၣ် (TTY: ၈၈၈-၇၈၁-၄၂၆) တက့ၢ်.

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Assistenzdienste zur Verfügung. Rufnummer: 800-524-9242 oder (TTY: 888-781-4262).

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь 800-524-9242 (телетайп: 888-781-4262).

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية، المجانية. اتصل بالرقم 800-524-9242 أو (خدمة الهاتف النصي: 888-781-4262).

सावधान: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंका लागि निःशुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ। 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस्।

ສິ່ງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາ ໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ທີ່ຕໍ່ຕິ. (TTY: 888-781-4262.)

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주의: 한국어를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-524-9242번 또는 (TTY: 888-781-4262)번으로 연락해 주십시오.

HEETINA To a wolwa Fulfulde laabi walliinde dow wolde, naa e njobdi, ene ngoodi ngam maada. Hebir 800-524-9242 malla (TTY: 888-781-4262).

ध्यान रखें : अगर आपकी भाषा हिन्दी है, तो आपके लिए भाषा सहायता सेवाएँ, निःशुल्क उपलब्ध हैं। 800-524-9242 पर संपर्क करें या (TTY: 888-781-4262)।

FUULEFFANNA: Yo isin Oromiffaa, kan dubbattan taatan, tajaajiloonni gargaarsa afaanii, kaffaltii malee, isiniif ni jiru. 800-524-9242 yookin (TTY: 888-781-4262) quunnamaa.

ATTENTION : si vous parlez français, des services d'assistance dans votre langue sont à votre disposition gratuitement. Appelez le 800 524 9242 (ou la ligne ATS au 888 781 4262).

УВАГА! Якщо ви розмовляєте українською мовою, для вас доступні безкоштовні послуги мовної підтримки. Зателефонуйте за номером 800-524-9242 або (телетайп: 888-781-4262).

Ge': Diné k'éhjí yáníłti'go níká bizaad bee áká' adoowoł, t'áá jiik'é, náhóló. Kojí' hółne' 800-524-9242 doodaii' (TTY: 888-781-4262)

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