**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 1-833-220-7903 or visit www.bcbsnd.com/plandocuments. 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 call 1-833-220-7903 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | For Preferred network providers **$3,500** individual / **$7,000** parent and child / **$7,000** parent and children / **$7,000** two person / **$7,000** family<br>For Enhanced network providers **$6,000** individual / **$12,000** parent and child / **$12,000** parent and children / **$12,000** two person / **$12,000** family<br>For Standard network providers / Nonparticipating providers **$10,500** individual / **$21,000** parent and child / **$21,000** parent and children / **$21,000** two person / **$21,000** family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes, preventive care. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | For Preferred network providers **$10,600** individual / **$21,200** parent and child / **$21,200** parent and children / **$21,200** two person / **$21,200** family<br>For Enhanced network providers **$10,600** individual / **$21,200** parent and child / **$21,200** parent and children / **$21,200** two person / **$21,200** family<br>For Standard network providers / Nonparticipating providers **$31,800** individual / **$63,600** parent and child / **$63,600** parent and children / **$63,600** two person / **$63,600** family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billed charges and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **Will you pay less if you use a network provider?** | Yes. See www.bcbsnd.com/find-a-doctor or call 1-833-220-7903 for a list of network providers. | You pay the least if you use a provider in the Preferred network. You pay more if you use a provider in the Enhanced or Standard network. You may pay the most if you use a Nonparticipating provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use a Nonparticipating provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |



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 |
|---|---|---|---|---|---|
| | | Preferred Network Provider (You will pay the least) | Enhanced Network Provider | Standard Network Provider / Nonparticipating Provider | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $20 copay/visit; deductible does not apply | 50% coinsurance | 50% coinsurance | None |
| | Specialist visit | $85 copay/visit; deductible does not apply | 50% coinsurance | 50% coinsurance | None |
| | Preventive care/screening/ immunization | No charge; deductible does not apply | No charge; deductible does not apply | No charge; deductible does not apply | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 40% coinsurance | 50% coinsurance | 50% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 40% coinsurance | 50% coinsurance | 50% coinsurance | None |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Preferred Network Provider (You will pay the least) | Enhanced Network Provider | Standard Network Provider / Nonparticipating Provider | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.bcbsnd.com/members/rx-tools | Value drugs | $5 copay/ prescription; deductible does not apply (retail & mail order) | $5 copay/ prescription; deductible does not apply (retail & mail order) | $5 copay/ prescription; deductible does not apply (retail & mail order) | Benefits are subject to the copay application described in the benefit plan. *See section 1.<br><br>Retail and Mail Order drugs must be received from a participating pharmacy. |
| | Preferred Generic | $20 copay/ prescription; deductible does not apply (retail & mail order) | $20 copay/ prescription; deductible does not apply (retail & mail order) | $20 copay/ prescription; deductible does not apply (retail & mail order) | |
| | Generic | $20 copay/ prescription; deductible does not apply (retail & mail order) | $20 copay/ prescription; deductible does not apply (retail & mail order) | $20 copay/ prescription; deductible does not apply (retail & mail order) | |
| | Preferred Brand Name | $150 copay/ prescription; deductible does not apply (retail & mail order) | $150 copay/ prescription; deductible does not apply (retail & mail order) | $150 copay/ prescription; deductible does not apply (retail & mail order) | |
| | Brand Name | $200 copay/ prescription; deductible does not apply (retail & mail order) | $200 copay/ prescription; deductible does not apply (retail & mail order) | $200 copay/ prescription; deductible does not apply (retail & mail order) | |
| | Preferred Specialty | 50% coinsurance | 50% coinsurance | 50% coinsurance | Specialty drugs must be received from the participating specialty pharmacy network. |
| | Specialty | 50% coinsurance | 50% coinsurance | 50% coinsurance | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 40% coinsurance | 50% coinsurance | 50% coinsurance | None |
| | Physician/surgeon fees | 40% coinsurance | 50% coinsurance | 50% coinsurance | None |

*For more information about limitations and exceptions, see the plan or policy document at www.bcbsnd.com/plandocuments.

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Preferred Network Provider (You will pay the least) | Enhanced Network Provider | Standard Network Provider / Nonparticipating Provider | |
| **If you need immediate medical attention** | Emergency room care | 40% coinsurance | 40% coinsurance; Preferred network deductible applies | 40% coinsurance; Preferred network deductible applies | None |
| | Emergency medical transportation | 40% coinsurance | 40% coinsurance; Preferred network deductible applies | 40% coinsurance; Preferred network deductible applies | None |
| | Urgent care | $20 copay/visit; deductible does not apply | 50% coinsurance | 50% coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 40% coinsurance | 50% coinsurance | 50% coinsurance | Prior Authorization may be required. |
| | Physician/surgeon fees | 40% coinsurance | 50% coinsurance | 50% coinsurance | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $20 copay/office visit; deductible does not apply<br><br>40% coinsurance for other outpatient services | 40% coinsurance/ office visit; Preferred network deductible applies<br><br>40% coinsurance for other outpatient services; Preferred network deductible applies | 50% coinsurance/ office visit<br><br>50% coinsurance for other outpatient services | Prior Authorization may be required. |
| | Inpatient services | 40% coinsurance | 40% coinsurance; Preferred network deductible applies | 50% coinsurance | Prior Authorization may be required. |
| **If you are pregnant** | Office visits | No charge; deductible does not apply | No charge; deductible does not apply | 50% coinsurance | None |
| | Childbirth/delivery professional services | 40% coinsurance | 50% coinsurance | 50% coinsurance | None |
| | Childbirth/delivery facility services | 40% coinsurance | 50% coinsurance | 50% coinsurance | None |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Preferred Network Provider (You will pay the least) | Enhanced Network Provider | Standard Network Provider / Nonparticipating Provider | |
| **If you need help recovering or have other special health needs** | Home health care | 40% coinsurance | 50% coinsurance | 50% coinsurance | 40 visits max/benefit period may apply. Prior Authorization may be required. |
| | Rehabilitation services | $20 copay/visit; deductible does not apply | 50% coinsurance | 50% coinsurance | 30 visits max/benefit period may apply for each therapy: physical, occupational and speech. |
| | Habilitation services | $20 copay/visit; deductible does not apply | 50% coinsurance | 50% coinsurance | 30 visits max/benefit period may apply for each therapy: physical, occupational and speech. |
| | Skilled nursing care | 40% coinsurance | 50% coinsurance | 50% coinsurance | 30 days max/benefit period may apply. Prior Authorization may be required. |
| | Durable medical equipment | 40% coinsurance | 50% coinsurance | 50% coinsurance | Prior Authorization may be required. |
| | Hospice services | 40% coinsurance | 50% coinsurance | 50% coinsurance | None |
| **If your child needs dental or eye care** | Children's eye exam | $40 copay/visit; deductible does not apply | $40 copay/visit; deductible does not apply | $40 copay/visit; deductible does not apply | One exam/benefit period. |
| | Children's glasses | 40% coinsurance | 40% coinsurance; Preferred network deductible applies | 40% coinsurance; Preferred network deductible applies | Lenses and frames are allowed 1/benefit period. |
| | Children's dental check-up | $40 copay/visit; deductible does not apply | $40 copay/visit; deductible does not apply | 50% coinsurance | Routine exam allowed 2/benefit period and cleanings allowed 4/benefit period. |

## 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.)**

- Abortions (except if necessary to prevent the woman's death)
- Acupuncture
- Cosmetic surgery
- Dental care (adult)
- Infertility treatment
- Long-term (custodial) care
- Non-emergency care when traveling outside the U.S.
- Nonformulary drugs
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care (except if medically necessary for members with circulatory disorders)
- Weight loss programs

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

- Bariatric surgery (lifetime maximum of 1 operative procedure may apply)
- Chiropractic care (20 visits/benefit period)
- Hearing aids (1 hearing aid per ear every 3 years)

**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: BCBSND at 1-833-220-7903 or www.bcbsnd.com; or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-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 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: North Dakota Insurance Department at 1-701-328-2440, 1-800-247-0560 or www.nd.gov/ndins/contact.

**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?** **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:**

See BCBSND's attached disclosure for information on available language assistance services.

*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 | $3,500 |
| Specialist copayment | $85 |
| Hospital (facility) coinsurance | 40% |
| Other coinsurance | 40% |

**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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $3,500 |
| Copayments | $10 |
| Coinsurance | $3,500 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$7,070** |

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

| | |
|---|---|
| The plan's overall deductible | $3,500 |
| Specialist copayment | $85 |
| Hospital (facility) coinsurance | 40% |
| Other coinsurance | 40% |

**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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $900 |
| Copayments | $700 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $200 |
| **The total Joe would pay is** | **$1,800** |

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

| | |
|---|---|
| The plan's overall deductible | $3,500 |
| Specialist copayment | $85 |
| Hospital (facility) coinsurance | 40% |
| Other coinsurance | 40% |

**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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,100 |
| Copayments | $300 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,400** |

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

**Blue Cross Blue Shield of North Dakota**
4510 13th Avenue South • Fargo, ND 58121

Blue Cross Blue Shield of North Dakota (BCBSND) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, gender identity, sexual orientation or sex. BCBSND does not exclude people or treat them differently because of race, color, national origin, age, disability, gender identity, sexual orientation or sex. BCBSND:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: 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, please call Member Services at 1-833-220-7903 (toll-free) or through the North Dakota Relay at 1-800-366-6888 or 711. If you believe BCBSND has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, gender identity, sexual orientation or sex, you can file a grievance with: Civil Rights Coordinator, 4510 13th Ave. S. Fargo, ND 58121, 701-297-1638 or North Dakota Relay at 800-366-6888 or 711, 701-282-1804 (fax), CivilRightsCoordinator@bcbsnd.com (email) (unencrypted emails present a risk.)

You can file a grievance in person or by mail, fax, or email within 180 days of the date of the alleged discrimination. Grievance forms are available at http://www.bcbsnd.com/report or by calling 1-833-220-7903. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. 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, 200 Independence Ave. S.W. Room 509F, HHH Building, Washington, DC 20201, 800-368-1019 or 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

**Español (Spanish) –** ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. También hay disponibles ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles sin cargo. Llame al 1-833-220-7903 (TTY: 1-800-366-6888 o 711) o hable con su proveedor.

**Deutsch (German) –** ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen kostenfreie fremdsprachliche Unterstützung zur Verfügung. Außerdem sind kostenlos entsprechende Hilfsmittel und Dienstleistungen zur Bereitstellung von Informationen in barrierefreien Formaten erhältlich. Rufen Sie 1-833-220-7903 (TTY: 1-800-366-6888 oder 711) an oder sprechen Sie mit Ihrem Anbieter.

**中文 (Chinese) –** 注意：如果您說中文，我們可以為您提供免費的語言協助服務。亦免費提供適當的輔助工具和服務，以無障礙格式提供資訊。請撥打 1-833-220-7903（聽障服務專線 TTY：1-800-366-6888 或 711）或與您的醫療服務提供者討論。

**Oromoo (Oromo) –** XIYYEEFFANNOO: Afaan Oromoo dubbattu yoo ta'e, tajaajilli gargaarsa afaan hiikuu kaffaltii malee ni argama. Gargaarsi dabalataa gargaaraadhaaf tajaajilli sirrii ta'ee fi odeeffannoo bifa dhaqqabamaa ta'een kennuunis bilisaan ni argama. Bilbili 1-833-220-7903 (TTY: 1-800-366-6888 or 711) ykn dhiyeessaa kee waliin haasa'i.

**Tiếng Việt (Vietnamese) –** CHÚ Ý: Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Chúng tôi cũng cung cấp miễn phí các dịch vụ và hỗ trợ bổ sung thích hợp để cung cấp thông tin ở các định dạng dễ tiếp cận. Xin gọi 1-833-220-7903 (TTY: 1-800-366-6888 hoặc 711) hoặc nói chuyện với nhà cung cấp của quý vị.

**Ikirundi (Bantu – Kirundi) –** Wiyubare: Nimba uvuga Ikirundi, wemerewe ubufasha bwo kuronka ururimi ku buntu. Wemerewe kandi ubufasha bukwiye bw'inyongera na serivisi vyo gutanga amakuru mu buryo bworoshe ku buntu. Hamagara kuri 1-833-220-7903 (TTY: 1-800-366-6888 canke 711) canke uvugane n'ujejwe kugufasha.

**العربية (Arabic) –** تنبيه: إذا كنت تتحدث العربية، فتتوفر لك خدمات المساعدة اللغوية المجانية. تتوفر أيضًا وسائل وخدمات إضافية مناسبة لتقديم المعلومات بتنسيقات سهلة الاستخدام من دون أي تكلفة. اتصل على الرقم: 1-833-220-7903 (الهاتف النصي: 1-800-366-6888 أو 711) أو تحدث إلى مقدم الرعاية المتابع لك.

**Kiswahili (Swahili) –** ZINGATIA: Ikiwa unazungumza Kiswahili, huduma za msaada wa lugha bila malipo zinapatikana kwa ajili yako. Vifaa na huduma saidizi zinazofaa ili kutoa taarifa katika miundo inayoweza kufikiwa pia hupatikana bila malipo. Piga simu 1-833-220-7903 (TTY: 1-800-366-6888 au 711) au zungumza na mtoa huduma wako.

**Русский (Russian) –** ВНИМАНИЕ! Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Также предоставляется дополнительная бесплатная помощь и услуги отображения информации в доступных форматах. Позвоните по телефону 1-833-220-7903 (TTY: 1-800-366-6888 или 711) или обратитесь к своему поставщику услуг.

**日本語 (Japanese) –** お知らせ：日本語をお話しになる方は無料の言語アシスタンスサービスをご利用いただけます。情報を利用可能な形式で提供するための適切な補助具やサービスも無料でご利用いただけます。1-833-220-7903（TTY：1-800-366-6888 または 711）にお電話いただくか、医療提供者にご相談ください。

**नेपाली (Nepali) –** ध्यान दिनुहोस्: तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि निःशुल्क भाषा सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक प्रविधि र सेवाहरू पनि निःशुल्क उपलब्ध छन्। 1-833-220-7903 (TTY: 1-800-366-6888 वा 711) मा कल गर्नुहोस् वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।

**Français (French) –** ATTENTION : Si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Vous pouvez aussi bénéficier gratuitement de l'accès à des outils et services auxiliaires appropriés dans des formats accessibles. Appelez le 1-833-220-7903 (ATS : 1-800-366-6888 ou 711) ou adressez-vous à votre fournisseur.

**한국어 (Korean) –** 주의: 한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 접근 가능한 형식으로 정보를 제공하는 적절한 보조 수단 및 서비스도 무료로 이용하실 수 있습니다. 1-833-220-7903(TTY: 1-800-366-6888 또는 711)번으로 전화하거나 담당 의료 서비스 제공자와 상의하십시오.

**Tagalog (Tagalog) –** PAUNAWA: Kung nagsasalita kayo ng Tagalog, mayroong kayong magagamit na libreng tulong na mga serbisyo sa wika. Mayroon ding mga angkop na auxiliary na tulong at serbisyo para magbigay ng impormasyon sa mga naa-access na format na makukuha ng walang singil. Tumawag sa 1-833-220-7903 (TTY: 1-800-366-6888 o 711) o makipag-usap sa iyong provider.

**Norsk (Norwegian) –** OBS: Hvis du snakker norsk, er gratis språkhjelp tilgjengelig for deg. Passende ytterligere hjelpemidler og tjenester for å oppgi informasjon i tilgjengelige formater er også tilgjengelig kostnadsfritt. Ring 1-833-220-7903 (TTY: 1-800-366-6888 eller 711) eller snakk med leverandøren din.

**Diné (Navajo) –** YÁ'ÁT'ÉÉH NITSÁHÁKEES: Díí Diné bizaad bee yáníłti'go, t'áá íiyisí t'áá bee yáhoot'ééł dóó baa áháyá' át'é. T'áá jíík'ehígíí bee na'ách'ąą' holne' dóó t'áá shikaadéé' danilį́į'ígíí t'áá jíík'ehgo bee hóló, dóó t'áá íiyisí doo béésh bee hadooleeł da. 1-833-220-7903 bee hojiiį' (TTY: 1-800-366-6888 dóó 711), dóó naaltsoos nínízingo bee iiná bee nił hane'ígíí nihił ch'á hodool'į'.