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, go to www.Medica.com/SelectPolicies-2023 or call 1-866-269-6806. 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 or call 1-866-269-6806 to request a copy.

| Important<br>Questions   | Answers  | Why This Matters:   |
|--|--|---|
| What is the overall<br>deductible?   | \$0 at Indian Health Care <u>Provider</u> (IHCP) or with IHCP <u>referral</u> at non-IHCP; \$2,500 individual / \$5,000 family for non-IHCP <u>network</u> services.         | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u><br>amount before this <u>plan</u> begins to pay. If you have other family members<br>on the <u>plan</u> , each family member must meet their own individual <u>deductible</u><br>until the total amount of <u>deductible</u> expenses paid by all family members<br>meets the overall family <u>deductible</u> .   |
| Are there services<br>covered before you<br>meet your<br><u>deductible</u> ? | Yes. <u>Preventive care</u> , preventive prescriptions and <u>copay</u> services from non-IHCP <u>network providers</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 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</u> <u>services</u> at <u>https://www.healthcare.gov/coverage/preventive-care-benefits</u> .                                       |
| Are there other<br>deductibles for<br>specific services?                     | No.  | You don't have to meet <u>deductibles</u> for specific services.  |
| What is the<br><u>out-of-pocket limit</u><br>for this <u>plan</u> ?          | \$9,100 individual / \$18,200 family for non-IHCP <u>network</u> services.   | 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<br>included in the<br><u>out-of-pocket limit</u> ?               | Premiums, balance-billing charges and health care this plan 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<br>you use a <u>network</u><br><u>provider</u> ?        | Yes. See <u>www.Medica.com/SearchSelectNetwork-2023</u> or call 1-866-269-6806 (TTY: 711) for a list of <u>network providers</u> .   | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an <u>out-of-network</u> 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 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<br><u>referral</u> to see a<br><u>specialist</u> ?             | No.  | You can see the <u>specialist</u> you choose without a <u>referral</u> .  |



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

|   | Services You May<br>Need                            |   | What You Will Pay  |  |  |
|---|---|---|--|--|--|
| Common Medical<br>Event   |   | Indian Health Care Provider<br>(IHCP)<br>(You will pay the least) | Provider   | Non-IHCP<br>Non-Network<br>Provider<br>(You will pay the most) | Limitations, Exceptions & Other Important<br>Information   |
| lf you visit a health<br>care <u>provider's</u><br>office or clinic | Primary care visit to<br>treat an injury or illness | No charge   | Primary care: 50%<br>coinsurance<br>Retail health clinics:<br>50% coinsurance<br>Chiropractic care: 50%<br>coinsurance | NOL COVERED  | Cost sharing waived at non-IHCP with IHCP referral.  |
|   | <u>Specialist</u> visit                             | No charge   | 50% coinsurance  | Not covered  | Cost sharing waived at non-IHCP with IHCP referral.  |
|   | Preventive care/<br>screening/immunization          |   | No charge. <u>Deductible</u><br>does not apply.  | Not covered  | You may have to pay for services that aren't<br>preventive. Ask your <u>provider</u> if the services<br>needed are preventive. Then check what your<br><u>plan</u> will pay for. <u>Cost sharing</u> waived at<br>non-IHCP with IHCP <u>referral</u> . |
| lf you have a test  |   | •   | 50% <u>coinsurance</u>   | Not covered  | Cost sharing waived at non-IHCP with IHCP referral.  |
|   | Imaging (CT/PET scans,<br>MRIs)                     | No charge   | 50% coinsurance  | Not covered  | *May require prior authorization. <u>Cost sharing</u> waived at non-IHCP with IHCP referral.   |

## Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services Mo Select by Medica Bronze Share Plus Limited

Coverage Period: Beginning on or after 01/01/2023 Coverage for: Individual or Family | Plan Type: EPO

|   |  |   | What You Will Pay  | Limitations, Exceptions & Other Important<br>Information<br>st) |   |
|---|--|---|--|---|---|
| Common Medical<br>Event   | Services You May<br>Need                             | ndian Health Care Provider<br>(IHCP)<br>(You will pay the least)<br>Non-IHCP Network<br>Provider<br>(You will pay more)<br>(You will pay the mo |  |   |   |
| If you need drugs to<br>treat your illness or<br>condition                        | Generic drugs  | No charge   | Preferred Generic: \$15<br>copay/prescription.<br>Deductible does not<br>apply.<br>Generic: \$20<br>copay/prescription.<br>Deductible does not<br>apply. | Not covered   | Up to a 31-day supply per prescription. *May require prior authorization. For non-preferred retail drugs, 50% <u>coinsurance</u> for orally-administered cancer treatment medications. Proton pump inhibitors (except for                         |
| More information<br>about <u>prescription</u><br>drug coverage is<br>available at | Preferred brand drugs                                | No charge   | \$200  | Not covered   | members 12 years of age and younger, and<br>those members who have a feeding tube) and<br>non-sedating antihistamines are not covered.<br>Insulin: Your cost-share will not exceed \$25 per<br>retail prescription unit. *Refer to the Exceptions |
| www.Medica.com/<br>MODrugList-2023  | Non-Preferred brand drugs                            | No charge   | 70% <u>coinsurance</u>   | Not covered   | to the Drug List section of your Policy of Coverage for more details. No charge for   |
|   | Specialty drugs                                      | No charge   | \$750<br><u>copay</u> /prescription.<br><u>Deductible</u> does not<br>apply.   | Not covered   | preventive drugs. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> .  |
| lit you nave  | Facility fee (e.g.,<br>ambulatory surgery<br>center) | No charge   | 50% coinsurance  | Not covered   | *May require prior authorization. <u>Cost sharing</u> waived at non-IHCP with IHCP referral.  |
| outpatient surgery  | Physician/surgeon fees                               | No charge   | 50% coinsurance  | Not covered   | *May require prior authorization. Cost sharing waived at non-IHCP with IHCP referral.   |
|   | Emergency room care                                  | No charge   | 50% coinsurance  | 50% coinsurance   | Network deductible applies. Cost sharing waived at non-IHCP with IHCP referral.   |
| lf you need   | Emergency medical<br>transportation                  | No charge   | 50% <u>coinsurance</u>   | 50% coinsurance   | Network deductible applies. Cost sharing waived at non-IHCP with IHCP referral.   |
| immediate medical<br>attention  | Urgent care  | No charge   | 50% coinsurance  | 50% <u>coinsurance</u>  | Network deductible applies. If a non-network provider charges more than the allowed amount, you may have to pay the difference (balance billing). Cost sharing waived at non-IHCP with IHCP referral.   |
| lf you have a   | Facility fee (e.g.,<br>hospital room)                | No charge   | 50% <u>coinsurance</u>   | Not covered   | *May require prior authorization. <u>Cost sharing</u> waived at non-IHCP with IHCP referral.  |
| hospital stay   | Physician/surgeon fees                               | No charge   | 50% <u>coinsurance</u>   | Not covered   | *May require prior authorization. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> .  |

\* For more information about limitations and exceptions, see the plan or policy document at <u>www.Medica.com/SelectPolicies-2023</u>.

# Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services Mo Select by Medica Bronze Share Plus Limited

Coverage Period: Beginning on or after 01/01/2023 Coverage for: Individual or Family | Plan Type: EPO

|   |  |   | What You Will Pay   |  |  |  |
|---|--|---|---|--|--|--|
| Common Medical<br>Event   | Services You May<br>Need                     | Indian Health Care Provider<br>(IHCP)<br>(You will pay the least) | Non-IHCP Network<br>Provider<br>(You will pay more)                         | Non-IHCP<br>Non-Network<br>Provider<br>(You will pay the most) | Limitations, Exceptions & Other Important<br>Information<br>t)   |  |
| If you need mental<br>health, behavioral                                | Outpatient services                          | No charge   | 50% <u>coinsurance</u>  | Not covered  | *May require prior authorization. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> .   |  |
| health, or<br>substance abuse<br>services                               | Inpatient services                           | No charge   | 50% <u>coinsurance</u>  | Not covered  | *May require prior authorization. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> .   |  |
|   | Office visits                                | No charge   | Prenatal: 50%<br><u>coinsurance</u><br>Postnatal: 50%<br><u>coinsurance</u> | Not covered  | <u>Cost sharing</u> does not apply for <u>preventive</u><br><u>services</u> . Depending on the type of services, a<br><u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may   |  |
| If you are pregnant   | Childbirth/delivery<br>professional services | No charge   | 50% <u>coinsurance</u>  | Not covered  | apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing waived at non-IHCP   |  |
|   | Childbirth/delivery<br>facility services     | No charge   | 50% <u>coinsurance</u>  | Not covered  | with IHCP referral.  |  |
| If you need help<br>recovering or have<br>other special health<br>needs | Home health care                             | No charge   | 50% <u>coinsurance</u>  | Not covered  | *May require prior authorization. Limited to 100 intermittent skilled nursing visits and 82 extended hours home care visits/year. Cost sharing waive at non-IHCP with IHCP referral.   |  |
|   | Rehabilitation services                      | No charge   | 50% <u>coinsurance</u>  | Not covered  | Outpatient: Limited to 20 physical therapy and 20 occupational therapy visits/year, unless medically necessary; Cardiac <u>rehabilitation</u> 36 visits/year. This visit limit does not apply to services for treatment of autism spectrum disorder. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> .                            |  |
|   | Habilitation services                        | No charge   | 50% <u>coinsurance</u>  | Not covered  | Outpatient: Limited to 20 physical therapy and 20 occupational therapy visits/year, unless medically necessary; Cardiac <u>rehabilitation</u> 36 visits/year. This visit limit does not apply with respect to services for mental health and substance use disorder conditions. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> . |  |
|   | Skilled nursing care                         | No charge   | 50% coinsurance   | Not covered  | *May require prior authorization. Limited to 150 days/year. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> .   |  |
|   | Durable medical<br>equipment                 | No charge 50% <u>coinsurance</u> Not cover                        |   | Not covered  | *May require prior authorization. <u>Cost sharing</u> waived at non-IHCP with IHCP referral.   |  |
|   | Hospice services                             | No charge   | 50% <u>coinsurance</u>  | Not covered  | Cost sharing waived at non-IHCP with IHCP referral.  |  |

\* For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.Medica.com/SelectPolicies-2023</u>.

## Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services Mo Select by Medica Bronze Share Plus Limited

Coverage Period: Beginning on or after 01/01/2023 Coverage for: Individual or Family | Plan Type: EPO

|   | Services You May<br>Need      |   | What You Will Pay                                   |  |  |
|---|-------------------------------|---|---|--|--|
| Common Medical<br>Event                   |                               | Indian Health Care Provider<br>(IHCP)<br>(You will pay the least) | Non-IHCP Network<br>Provider<br>(You will pay more) | Non-IHCP<br>Non-Network<br>Provider<br>(You will pay the most) | Limitations, Exceptions & Other Important<br>Information   |
| lf your child needs<br>dental or eye care | Children's eye exam           | No charge   | 50% coinsurance                                     | Not covered  | Coverage limited to end of month member turns 19. <u>Cost sharing</u> waived at non-IHCP with IHCP referral.   |
|   | Children's glasses            | No charge   | 50% <u>coinsurance</u>                              | Not covered  | Limited to one pair of glasses/year and one pair<br>of contacts/year to end of month member turns<br>19. <u>Cost sharing</u> waived at non-IHCP with IHCP<br>referral. |
|   | Children's dental<br>check-up | Not covered   | Not covered   | Not covered  | Coverage is available through a stand-alone dental policy.   |

## **Excluded Services & Other Covered Services:**

| <ul> <li>Abortions, elective, induced, except as medically necessary to protect the life of the mother</li> <li>Acupuncture</li> <li>Bariatric surgery</li> </ul> | <ul> <li>Cosmetic surgery</li> <li>Dental care (Adult)</li> <li>Dental care (Child) (coverage is available through a stand-alone dental policy)</li> <li>Dental check-up</li> <li>Infertility treatment</li> <li>Long-term care</li> </ul> | <ul> <li>Non-emergency care when traveling outside the U.S.</li> <li>Routine eye care (Adult)</li> <li>Routine foot care except for some conditions</li> <li>Weight loss programs</li> </ul> |
|---|--|--|
| Other Covered Services (Limitations may apply to the  | ese services. This isn't a complete list. Please see your  | plan document.)  |
|   |  |  |

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services MO Select by Medica Bronze Share Plus Limited

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: Medica at 1-866-269-6806, the Missouri Department of Insurance, Consumer Affairs Division, 1-800-726-7390 or <a href="https://www.insurance.mo.gov/consumers/complaints/index.php">www.insurance.mo.gov/consumers/complaints/index.php</a>, or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <a href="https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa">https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa</a>. Other coverage options may be available to you, too, including buying individual insurance coverage through the <a href="https://www.HealthCare.gov">Health Insurance Marketplace</a>. For more information about the Marketplace, visit <a href="https://www.HealthCare.gov">www.HealthCare.gov</a> or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: Medica at 1-866-269-6806, the Missouri Department of Insurance, Consumer Affairs Division, 1-800-726-7390 or <u>www.insurance.mo.gov/consumers/complaints/index.php</u>.

#### 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? 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 1-888-592-8211. Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-592-8211. Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-592-8211. Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-592-8211.

To see examples of how this <u>plan</u> 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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

| <b>Peg is Having a Baby</b><br>(9 months of in-network pre-natal care<br>delivery)   | e and a hospital | Managing Joe's Type 2 Diabet<br>(a year of routine in-network care of a we<br>condition)   | t <b>es</b><br>ell-controlled | Mia's Simple Fracture<br>(in-network emergency room visit and fo  | bllow up care) |
|--|------------------|--|-------------------------------|---|----------------|
| The plan's overall deductible  | \$0              | The plan's overall deductible  | \$0                           | The plan's overall deductible   | \$0            |
| Specialist coinsurance   | 0%               | Specialist coinsurance   | 0%                            | Specialist coinsurance  | 0%             |
| Hospital (facility) <u>coinsurance</u>   | 0%               | <ul> <li>Hospital (facility) coinsurance</li> </ul>  | 0%                            | <ul> <li>Hospital (facility) <u>coinsurance</u></li> </ul>  | 0%             |
| • Other <u>coinsurance</u>   | 0%               | Other <u>coinsurance</u>   | 0%                            | Other <u>coinsurance</u>  | 0%             |
| This EXAMPLE event includes service<br><u>Specialist</u> office visits ( <i>prenatal care</i> )<br>Childbirth/Delivery Professional Services<br>Childbirth/Delivery Facility Services<br><u>Diagnostic tests</u> ( <i>ultrasounds and blood</i><br><u>Specialist</u> visit ( <i>anesthesia</i> ) | es               | This EXAMPLE event includes services<br><u>Primary care physician</u> office visits ( <i>includi</i><br><i>education</i> )<br><u>Diagnostic tests</u> ( <i>blood work</i> )<br><u>Prescription drugs</u><br><u>Durable medical equipment</u> ( <i>glucose mete</i> | ng disease                    | This EXAMPLE event includes services<br>Emergency room care (including medical<br>Diagnostic test (x-ray)<br>Durable medical equipment (crutches)<br>Rehabilitation services (physical therapy) | supplies)      |
| Total Example Cost   | \$12,700         | Total Example Cost   | \$5,600                       | Total Example Cost  | \$2,800        |
| In this example, Peg would pay:  |                  | In this example, Joe would pay:  |                               | In this example, Mia would pay:   |                |
| Cost Sharing   |                  | Cost Sharing   |                               | Cost Sharing  |                |
| Deductibles  | \$0              | Deductibles  | \$0                           | Deductibles   | \$0            |
| <u>Copayments</u>  | \$0              | <u>Copayments</u>  | \$0                           | <u>Copayments</u>   | \$0            |
| Coinsurance  | \$0              | Coinsurance  | \$0                           | Coinsurance   | \$0            |
| What isn't covered   |                  | What isn't covered   |                               | What isn't covered  |                |
| Limits or exclusions   | \$60             | Limits or exclusions   | \$0                           | Limits or exclusions  | \$0            |
| The total Peg would pay is   | \$60             | The total Joe would pay is   | \$0                           | The total Mia would pay is  | \$0            |

Note: These numbers assume the patient received care from an IHCP <u>provider</u> or with IHCP <u>referral</u> at a non-IHCP. If you receive care from a non-IHCP <u>provider</u> without a <u>referral</u> from an IHCP your costs may be higher.

The <u>plan</u> would be responsible for the other costs of these EXAMPLE covered services.

#### Discrimination is Against the Law

Medica complies with applicable Federal civil rights laws and will not discriminate against any person on the basis of race, color, national origin, age, disability or sex. Medica:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: TTY communication and written information in other formats (large print, audio, 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, call the number included in this document or on the back of your Medica ID card. If you believe that Medica has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Civil Rights Coordinator, Mail Route CP250, PO Box 9310, Minneapolis, MN 55443-9310, 952-992-3422 (phone/fax), TTY 711, civilrightscoordinator@medica.com.

You can file a grievance in person or by mail, fax, or email. You may also contact the Civil Rights Coordinator if you need assistance with filing a complaint.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

# If you want free help translating this information, call the number included in this document or on the back of your Medica ID card.

Si desea asistencia gratuita para traducir esta información, llame al número que figura en este documento o en la parte posterior de su tarjeta de identificación de Medica.

Yog koj xav tau kev pab dawb kom txhais daim ntawv no, hu rau tus xov tooj nyob hauv daim ntawv no los yog nyob nraum qab ntawm koj daim npav Medica ID.

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Nếu quý vị muốn trợ giúp dịch thông tin này miễn phí, hãy gọi vào số có trong tài liệu này hoặc ở mặt sau thẻ ID Medica của quý vị.

Odeeffannoo kana gargaarsa tolaan akka isinii hiikamu yoo barbaaddan, lakkoobsa barruu kana keessatti argamu ykn ka dugda kaardii Waraqaa Eenyummaa Medica irra jiruun bilbila'a.

اذاكنت تريدمساعدة مجانبة في ترجمة هذه المعلومات, فاتصل على ألرقم الوارد في هذه الوثيقة أو على ظهر بطاقة تعريف ميديكا الخاصة بك.

Если Вы хотите получить бесплатную помощь в переводе этой информации, позвоните по номеру телефона, указанному в данном документе и на обратной стороне Вашей индентификационной карты Medica.

່ ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປຂໍ້ມູນນີ້ຟຣີ, ໃຫ້ໂທຫາເລກໜາຍ ທີ່ມີຢູ່ໃນເອກະສານນີ້ ຫຼື ຢູ່ດ້ານຫຼັງຂອງບັດ Medica ຂອງທ່ານ. 이 정보를 번역하는 데 무료로 도움을 받고 싶으시면, 이 문서에 포함된 전화번호나 Medica ID 카드 뒷면의 전화번호로 전화하십시오.

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နမ့်၊အဲဉ်ိဳးတဂ်ကိုးထံစၢၤကလီနှုန်းတင်္ဂုတ်ကို၊အံၤလ၊အကလီနှဉ်,ကိုးလီတဲစိနီဉ်င်္ဂလ၊အပဉ် ယှာ်လ၊လ်ာတီလံာမီအပူ၊အံၤမ့တမ့၊ဖဲနန္နနိုင်ခလော်အုဉ်သးဓးက့အလို၊ခံတကပၤအဖိခ်ဉ်နှဉ်တက္ဂါ.

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