



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 <https://regence.com> or call 1 (866) 240-9580. 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 healthcare.gov/sbc-glossary or call 1 (866) 240-9580 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	\$300 individual / \$900 family per calendar year.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. Certain <u>preventive care</u> , <u>prescription drug coverage</u> and those services listed below as " <u>deductible</u> does not apply."	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 healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	In- <u>network provider</u> : \$2,500 individual / \$7,500 family per calendar year. Out-of- <u>network provider</u> : \$6,000 individual per calendar year.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See https://regence.com/go/OR/Preferred or call 1 (866) 240-9580 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$5 <u>copay</u> , <u>deductible</u> does not apply / first 3 upfront visits / year; \$35 <u>copay</u> / office visit after 3 upfront visits, <u>deductible</u> does not apply; 30% <u>coinsurance</u> for all other services	50% <u>coinsurance</u>	First 3 upfront visits combined for primary care and behavioral health services. <u>Copayment</u> applies to each in- <u>network provider</u> office visit only. All other services are covered at the <u>coinsurance</u> specified, after <u>deductible</u> .
	<u>Specialist</u> visit	\$35 <u>copay</u> / office visit, <u>deductible</u> does not apply; 30% <u>coinsurance</u> for all other services	50% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	No charge, <u>deductible</u> does not apply	50% <u>coinsurance</u>	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	30% <u>coinsurance</u> , <u>deductible</u> does not apply for outpatient services	50% <u>coinsurance</u>	Preauthorization may be required.
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://regence.com/go/2024/OR/4tier	Tier 1 (Typically, generic drugs with highest overall value)	\$10 <u>copay</u> , <u>deductible</u> does not apply / retail prescription; \$10 <u>copay</u> , <u>deductible</u> does not apply / home delivery prescription; \$10 <u>copay</u> , <u>deductible</u> does not apply / self-	\$10 <u>copay</u> , <u>deductible</u> does not apply / retail prescription; \$10 <u>copay</u> , <u>deductible</u> does not apply / home delivery prescription; \$10 <u>copay</u> , <u>deductible</u> does not apply / self-	<u>Prescription drugs</u> not on the Drug List are not covered, unless an exception is approved. 30-day supply / retail prescription 90-day supply / home delivery prescription 30-day supply / <u>specialty drug</u> prescription <u>Specialty drugs</u> are not available through home delivery. Coverage includes compound medications at 50% <u>coinsurance</u> , <u>deductible</u> does not apply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		administrable cancer chemotherapy prescription	administrable cancer chemotherapy prescription	<p><u>Cost shares</u> for insulin will not exceed \$85 / 30-day supply retail prescription or \$255 / 90-day supply home delivery prescription.</p> <p>No charge, <u>deductible</u> does not apply for certain preventive drugs, contraceptives and immunizations at a participating pharmacy.</p> <p>If you fill a brand drug or <u>specialty drug</u> when there is an equivalent generic drug or specialty biosimilar drug available, you pay the difference in cost in addition to the <u>copayment</u> and/or <u>coinsurance</u>.</p> <p>The first fill of <u>specialty drugs</u> may be provided by a retail pharmacy; additional refills must be provided by a specialty pharmacy.</p>
	Tier 2 (Typically, brand drugs with moderate overall value)	\$30 <u>copay</u> , <u>deductible</u> does not apply / retail prescription;	\$30 <u>copay</u> , <u>deductible</u> does not apply / retail prescription;	
		\$60 <u>copay</u> , <u>deductible</u> does not apply / home delivery prescription;	\$60 <u>copay</u> , <u>deductible</u> does not apply / home delivery prescription;	
		\$50 <u>copay</u> , <u>deductible</u> does not apply / self-administrable cancer chemotherapy prescription	\$50 <u>copay</u> , <u>deductible</u> does not apply / self-administrable cancer chemotherapy prescription	
	Tier 3 (Typically, brand drugs with lower overall value)	\$50 <u>copay</u> , <u>deductible</u> does not apply / retail prescription;	\$50 <u>copay</u> , <u>deductible</u> does not apply / retail prescription;	
\$100 <u>copay</u> , <u>deductible</u> does not apply / home delivery prescription; \$100 <u>copay</u> , <u>deductible</u> does not apply / self-administrable cancer chemotherapy prescription		\$100 <u>copay</u> , <u>deductible</u> does not apply / home delivery prescription; \$100 <u>copay</u> , <u>deductible</u> does not apply / self-administrable cancer chemotherapy prescription		
Tier 4 (<u>Specialty drugs</u>)	30% up to \$200 maximum, <u>deductible</u> does not apply / <u>specialty drug</u>	30% up to \$200 maximum, <u>deductible</u> does not apply / <u>specialty drug</u>		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	30% <u>coinsurance</u> after \$250 <u>copay</u> / visit, <u>deductible</u> does not apply	30% <u>coinsurance</u> after \$250 <u>copay</u> / visit, <u>deductible</u> does not apply	<u>Copayment</u> applies to the facility charge for each visit (waived if admitted).
	<u>Emergency medical transportation</u>	No charge, <u>deductible</u> does not apply	No charge, <u>deductible</u> does not apply	None
	<u>Urgent care</u>	\$35 <u>copay</u> / office visit, <u>deductible</u> does not apply; 30% <u>coinsurance</u> for all other services	50% <u>coinsurance</u>	<u>Copayment</u> applies to each in-network provider office visit only. All other services are covered at the <u>coinsurance</u> specified, after <u>deductible</u> .
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Preauthorization required for some inpatient services.
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$5 <u>copay</u> , <u>deductible</u> does not apply / first 3 upfront visits / year;	50% <u>coinsurance</u>	First 3 upfront visits combined for primary care and behavioral health services. <u>Copayment</u> applies to each in-network provider office/psychotherapy visit only. All other services are covered at the <u>coinsurance</u> specified, after <u>deductible</u> .
		\$35 <u>copay</u> / office visit after 3 upfront visits, <u>deductible</u> does not apply;		
	Inpatient services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you are pregnant	Office visits	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	130 visits / year Preauthorization required.
	<u>Rehabilitation services</u>	30% <u>coinsurance</u> , <u>deductible</u> does not apply	50% <u>coinsurance</u>	30 inpatient days / year 60 inpatient days for each head or spinal cord injury

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		for outpatient services		30 outpatient visits / year Includes physical therapy, occupational therapy and speech therapy. Preauthorization required for inpatient services.
	<u>Habilitation services</u>	30% <u>coinsurance</u> , <u>deductible</u> does not apply	50% <u>coinsurance</u>	30 neurodevelopmental visits / year Neurodevelopmental therapy limited to individuals under age 18. Includes physical therapy, occupational therapy and speech therapy.
	<u>Skilled nursing care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	60 inpatient days / year Preauthorization required.
	<u>Durable medical equipment</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	1 wig / year after chemotherapy or radiation therapy Preauthorization may be required.
	<u>Hospice services</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	30 respite inpatient or outpatient days / lifetime Preauthorization required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

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, except congenital anomalies
- Custodial Care
- Dental care
- Infertility treatment
- Long-term care
- Private-duty nursing
- Recreation therapy
- Routine eye care
- Routine foot care, except for diabetic patients
- Weight loss programs

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

- Abortion
- Acupuncture, 30 visits / year
- Bariatric surgery
- Chiropractic care, 30 visits / year
- Hearing aids, 1 per ear / year
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1 (877) 267-2323 ext. 61565 or cciio.cms.gov or your state insurance department. You may also contact the plan at 1 (866) 240-9580. 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 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 the plan at 1 (866) 240-9580 or visit regence.com or the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or dol.gov/ebsa/healthreform. You may also contact the Oregon Division of Financial Regulation by calling 1 (503) 947-7984 or the toll-free message line at 1 (888) 877-4894; by writing to the Oregon Division of Financial Regulation, Consumer Advocacy Unit, P.O. Box 14480, Salem, OR 97309-0405; through the Internet at: dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx; or by E-mail at: DFRInsuranceHelp@oregon.gov.

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](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1 (866) 240-9580.

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** **\$300**
- **Specialist copayment** **\$35**
- **Hospital (facility) coinsurance** **30%**
- **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*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing

<u>Deductibles</u>	\$300
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,200

What isn't covered

Limits or exclusions	\$60
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The total Peg would pay is	\$2,560
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Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **\$300**
- **Specialist copayment** **\$35**
- **Hospital (facility) coinsurance** **30%**
- **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*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing

<u>Deductibles</u>	\$300
<u>Copayments</u>	\$700
<u>Coinsurance</u>	\$200

What isn't covered

Limits or exclusions	\$200
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The total Joe would pay is	\$1,400
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Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **\$300**
- **Specialist copayment** **\$35**
- **Hospital (facility) coinsurance** **30%**
- **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*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing

<u>Deductibles</u>	\$300
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$600

What isn't covered

Limits or exclusions	\$0
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The total Mia would pay is	\$1,300
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The plan would be responsible for the other costs of these EXAMPLE covered services.



The Summary of Benefits and Coverage (SBC) document will help you choose a vision plan. The SBC shows you how you and the plan would share the cost for covered vision 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 <https://regence.com>. For provider or benefit questions call VSP at 1 (844) 299-3041. For membership questions call Regence at 1 (866) 240-9580. 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 healthcare.gov/sbc-glossary or call 1 (866) 240-9580 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$0	See the Common Vision Event chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	Not applicable.	See the Common Vision Event chart below for your costs for services this <u>plan</u> covers.
Are there other <u>deductibles</u> for specific services?	No.	See the Common Vision Event chart below for your costs for services this <u>plan</u> covers.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Not applicable.	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Not applicable.	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
Will you pay less if you use a <u>network provider</u> ?	Yes. See https://regence.com/go/OR/VSPNetwork or call 1 (844) 299-3041 for a list of VSP doctors.	This <u>plan</u> uses a vision <u>provider network</u> (Vision Service Plan). You will pay less if you use a vision <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network</u> vision <u>provider</u> , and you might receive a bill from a vision <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>).
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> .

Common Vision Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		VSP Doctor (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a vision care <u>provider's</u> office or clinic	Routine vision examination	\$35 <u>copay</u> , then no charge	\$35 <u>copay</u> , then no charge up to the <u>out-of-network provider</u> limit	For services provided by an <u>out-of-network provider</u> , you pay all charges up front then submit a <u>claim</u> for reimbursement. 1 routine eye examination / calendar year Routine eye examination limited to \$45 for <u>out-of-network providers</u> .
	Vision hardware	No charge up to the limit	No charge up to the limit	For services provided by an <u>out-of-network provider</u> , you pay all charges up front then submit a <u>claim</u> for reimbursement. Frames, lenses or contact lenses allowance is limited to \$250, and you pay any balance. Coverage for frames limited to one pair every calendar year. Coverage for lenses or contact lenses limited to one pair every calendar year. Contact lenses and fitting are in lieu of all other frame and lens benefits. When you receive contact lenses, you will not be eligible for any frames or lenses until the next calendar year.
	Contact lens evaluation and fitting examination	No charge	No charge up to the vision hardware limit	For services provided by an <u>out-of-network provider</u> , you pay all charges up front then submit a <u>claim</u> for reimbursement. 1 contact lens evaluation and fitting examination / calendar year Elective contact lens evaluation and fitting examination (including elective or necessary contact lenses) allowance limit combined with vision hardware.

Excluded 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.)

- Corrective vision treatment of an experimental nature
- Cosmetic services and supplies
- Fees, taxes and interest
- Low vision benefits
- Medical or surgical treatment of the eyes
- Non-direct patient care
- Orthoptics or vision training
- Plano lenses
- Two pair of glasses in lieu of bifocals

NONDISCRIMINATION NOTICE

Regence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Regence does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Regence:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, and accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services listed above, please contact:

Medicare Customer Service

1-800-541-8981 (TTY: 711)

Customer Service for all other plans

1-888-344-6347 (TTY: 711)

If you believe that Regence 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 our civil rights coordinator below.

For VSP vision services, contact: **VSP**
1-844-299-3041 (TTY: 1-800-428-4833)

VSP provides administration for your Regence vision plan. Regence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Regence does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Medicare Customer Service

Civil Rights Coordinator

MS: B32AG, PO Box 1827

Medford, OR 97501

1-866-749-0355, (TTY: 711)

Fax: 1-888-309-8784

medicareappeals@regence.com

Customer Service for all other plans

Civil Rights Coordinator

MS CS B32B, P.O. Box 1271

Portland, OR 97207-1271

1-888-344-6347, (TTY: 711)

CS@regence.com

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 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, DC 20201

1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at
<http://www.hhs.gov/ocr/office/file/index.html>.

Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-344-6347 (TTY: 711).

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 1-888-344-6347 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-344-6347 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-344-6347 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-344-6347 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-344-6347 (телетайп: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-344-6347 (ATS : 711)

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。1-888-344-6347 (TTY:711) まで、お電話にてご連絡ください。

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, kojì' hódíílnih 1-888-344-6347 (TTY: 711.)

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea te ke lava 'o ma'u ia. ha'o telefonimai mai ki he fika 1-888-344-6347 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-344-6347 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្អល គឺអាចមានសរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-344-6347 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-344-6347 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-888-344-6347 (TTY: 711)

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል፤ በሚከተለው ቁጥር ይደውሉ 1-888-344-6347 (መስማት ለተሳናቸው:- 711)::

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-344-6347 (телетайп: 711)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-344-6347 (टिडिवाइ: 711)

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-344-6347 (TTY: 711)

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-344-6347 (TTY: 711)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-344-6347 (TTY: 711)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ຄວນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-888-344-6347 (TTY: 711)

Afaan dubbattan Oroomiffaa tiif, tajaajila gargaarsa afaanii tola ni jira. 1-888-344-6347 (TTY: 711) tiin bilbilaa.

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-344-6347 (TTY: 711) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذاكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم 711 TTY)