



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 regence.com or call 1 (888) 367-2116. 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 (888) 367-2116 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> and those services listed below as " <u>deductible</u> does not apply" or as "No charge."	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> ?	\$1,500 individual / \$3,000 family 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-billed</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 regence.com/go/OR/Preferred or call 1 (888) 367-2116 for a list of <u>network providers</u> .	You pay the least if you use a <u>provider</u> in the preferred <u>network</u> . You pay more if you use a <u>provider</u> in the participating <u>network</u> . You will pay the most if you use a nonparticipating <u>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 a nonparticipating <u>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
		Preferred Network Provider (You pay the least)	Participating Network Provider (You pay more)	Nonparticipating Provider (You pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 <u>copay</u> / office visit, <u>deductible</u> does not apply; \$20 <u>copay</u> / retail clinic visit, <u>deductible</u> does not apply; 10% <u>coinsurance</u> for all other services	\$35 <u>copay</u> / office visit, <u>deductible</u> does not apply \$20 <u>copay</u> / retail clinic visit, <u>deductible</u> does not apply; 30% <u>coinsurance</u> for all other services	30% <u>coinsurance</u>	<p><u>Copayment</u> applies to each <u>preferred</u> or participating office visit only. All other services that are not billed as an office visit are covered at the <u>coinsurance</u> specified, after <u>deductible</u>. Coverage for acupuncture and chiropractic spinal manipulations is subject to \$25 <u>copayment</u> / visit, <u>deductible</u> does not apply. Limited to \$500 / year for all acupuncture and chiropractic spinal manipulations services combined.</p> <p><u>Coinsurance</u> and <u>deductible</u> do not apply for childhood immunizations from nonparticipating <u>providers</u>. 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.</p>
	<u>Specialist</u> visit	\$20 <u>copay</u> / office visit, <u>deductible</u> does not apply; 10% <u>coinsurance</u> for all other services	\$35 <u>copay</u> / office visit; <u>deductible</u> does not apply; 30% <u>coinsurance</u> for all other services	30% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	No charge	No charge	30% <u>coinsurance</u>	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge for the first \$400 / year, then 10% <u>coinsurance</u>	No charge for the first \$400 / year, then 30% <u>coinsurance</u>	No charge for the first \$400 / year, then 30% <u>coinsurance</u>	No charge for the first \$400 / year for all upfront outpatient <u>diagnostic tests</u> and imaging combined. Once the limit has been met and for all inpatient services, services are covered at the <u>coinsurance</u> specified, after <u>deductible</u> .
	Imaging (CT/PET scans, MRIs)	No charge for the first \$400 / year, then 10% <u>coinsurance</u>	No charge for the first \$400 / year, then 30% <u>coinsurance</u>	No charge for the first \$400 / year, then 30% <u>coinsurance</u>	
If you need drugs to treat your illness or condition	Generic drugs	\$10 <u>copay</u> / retail prescription \$30 <u>copay</u> / mail order prescription \$10 <u>copay</u> / self-administrable cancer chemotherapy prescription			Limited to a 90-day supply retail (1 <u>copayment</u> per 30-day supply), 90-day supply mail order or 30-day supply <u>specialty drugs</u> .

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You pay the least)	Participating Network Provider (You pay more)	Nonparticipating Provider (You pay the most)	
More information about prescription drug coverage is available at regence.com/go/druglist/2020/OR/3tier .	Preferred brand drugs	\$20 <u>copay</u> / retail prescription \$60 <u>copay</u> / mail order prescription \$50 <u>copay</u> / self-administrable cancer chemotherapy prescription			No charge for FDA-approved women's contraceptives and certain preventive drugs and immunizations at a participating pharmacy. Coverage includes compound medications at 50% <u>coinsurance</u> , refer to your <u>plan</u> for further information. You are responsible for the difference in cost between a dispensed brand-name drug and the equivalent generic drug, in addition to the <u>copayment</u> and/or <u>coinsurance</u> . The first fill for <u>specialty drugs</u> may be provided at a retail pharmacy, additional fills must be provided at a specialty pharmacy.
	Brand drugs	\$40 <u>copay</u> / retail prescription \$120 <u>copay</u> / mail order prescription \$100 <u>copay</u> / self-administrable cancer chemotherapy prescription			
	<u>Specialty drugs</u>	Refer to generic, preferred brand and brand drugs above.			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	5% <u>coinsurance</u> for ambulatory surgery centers; 10% <u>coinsurance</u> for all other facilities	30% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Physician/surgeon fees	5% <u>coinsurance</u> for ambulatory surgery center physicians; 10% <u>coinsurance</u> for all other physicians	30% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	10% <u>coinsurance</u> after \$100 <u>copay</u> / visit	10% <u>coinsurance</u> after \$100 <u>copay</u> / visit	10% <u>coinsurance</u> after \$100 <u>copay</u> / visit	<u>Copayment</u> applies to the facility charge for each visit (waived if admitted).
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	None
	<u>Urgent care</u>	Covered the same as the If you visit a health care provider's office or clinic (Primary care visit or <u>Specialist</u> visit) or If you have a test above.			None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You pay the least)	Participating Network Provider (You pay more)	Nonparticipating Provider (You pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <u>copay</u> / office visit, <u>deductible</u> does not apply; 10% <u>coinsurance</u> for all other services	\$20 <u>copay</u> / office visit, <u>deductible</u> does not apply; 10% <u>coinsurance</u> for all other services	30% <u>coinsurance</u> , <u>deductible</u> does not apply for outpatient therapy visits	<u>Copayment</u> applies to each <u>preferred</u> and participating <u>provider</u> outpatient office/psychotherapy visit only. All other outpatient services are covered at the <u>coinsurance</u> specified, after <u>deductible</u> .
	Inpatient services	10% <u>coinsurance</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you are pregnant	Office visits	10% <u>coinsurance</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, a <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	10% <u>coinsurance</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 130 visits / year.
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Inpatient limited to 30 days / year. Outpatient limited to 25 visits / year. Includes physical therapy, occupational therapy and speech therapy services.
	<u>Habilitation services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Outpatient neurodevelopmental therapy is limited to 25 visits / year. Neurodevelopmental therapy is limited to services for individuals through age 17. Includes physical therapy, occupational therapy and speech therapy services.
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 60 inpatient days / year.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Hospice services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Respite care is limited to 14 days / lifetime.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	Not covered	None

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.)

- Bariatric surgery
- Cosmetic surgery, except congenital anomalies
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs, unless required by law

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

- Acupuncture
- Chiropractic care, spinal manipulations only
- Hearing aids for individuals up to age 19, or individuals 19 years of age up to age 26 and enrolled in a secondary school or an accredited educational institution
- 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 x61565 or ccio.cms.gov or your state insurance department. You may also contact the plan at 1 (888) 367-2116. 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 (888) 367-2116 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 (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/gethelp/Pages/file-a-complaint.aspx; or by E-mail at: DFR.InsuranceHelp@oregon.gov.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 (888) 367-2116.

-----*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 <u>plan's overall deductible</u>	\$300
■ <u>Specialist copayment</u>	\$20
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

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	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$33
Coinsurance	\$1,151
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,544

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's overall deductible</u>	\$300
■ <u>Specialist copayment</u>	\$20
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

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	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,234
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$255
The total Joe would pay is	\$1,489

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's overall deductible</u>	\$300
■ <u>Specialist copayment</u>	\$20
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

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	\$1,925
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$120
Coinsurance	\$139
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$559



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This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to regence.com. For provider or benefit questions call VSP at 1 (844) 299-3041. For membership questions, call Regence at 1 (888) 367-2116. 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 (888) 367-2116 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$0	See the 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 chart below for your costs for services this <u>plan</u> covers.
Are there other <u>deductibles</u> for specific services?	No.	See the chart below for your costs for services this <u>plan</u> covers.
What is the <u>out-of-pocket limit</u> for this plan?	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 regence.com/go/OR/VSPNetwork or call 1 (844) 299-3041 for lists of VSP doctors or <u>out-of-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 an <u>out-of-network 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	Out-of-network Provider	
If you visit a vision care <u>provider's</u> office or clinic	Routine vision examination and vision hardware	No charge up to the VSP doctor limit	No charge up to the <u>out-of-network provider</u> limit	<p>Routine examination limited to 1 every calendar year, and limited to \$45 for an <u>out-of-network provider</u>.</p> <p>Coverage for frames limited to every calendar year. Frame or elective contact lens* allowance is limited to \$150 from VSP doctors. Frame allowance is limited to \$80 for VSP approved wholesale/retail vendor.</p> <p>Coverage for lenses limited to 1 pair (2 lenses) for glass or plastic single vision lenses, lined bifocal lenses, lined trifocal lenses, lenticular lenses, standard progressive lenses or elective contact lenses* every calendar year.</p> <p>Vision hardware allowance from an <u>out-of-network provider</u> limited to: \$70 for frames, \$30 for single vision lenses, \$50 for lined bifocal / standard progressive lenses, \$65 for lined trifocal lenses, \$100 for lenticular lenses, \$105 for elective contacts (includes fitting/evaluation services)*, or \$210 for necessary contact lenses (includes fitting/evaluation services).</p> <p>*Contact lenses are in lieu of all other frame and lens benefits. When you receive contact lenses, you will not be eligible for any frames and/or lenses until the next calendar year.</p>
	Contact lens evaluation and fitting examination	\$60 <u>copay</u>	No charge up to the <u>out-of-network provider</u> limit*	<p>Limited to 1 contact lens evaluation and fitting examination every calendar year.</p> <p>*Coverage from an <u>out-of-network provider</u> is included in the elective contact lens or necessary contact lens allowance described above.</p>

Common Vision Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		VSP Doctor	Out-of-network Provider	
	Low vision supplemental testing	No charge	No charge up to the <u>out-of-network provider limit</u>	Supplemental testing allowance limited to \$125 for <u>out-of-network providers</u> . Supplemental testing and supplemental aids limited to a combined maximum of \$1,000 once every 2 calendar years.
	Low vision supplemental aids	25% <u>coinsurance</u>	25% <u>coinsurance</u>	

Excluded Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> • Corrective vision treatment of an experimental nature • Cosmetic services and supplies • Fees, taxes, interest 	<ul style="list-style-type: none"> • Medical or surgical treatment of the eyes • Non-direct patient care • Orthoptics or vision training 	<ul style="list-style-type: none"> • Personal comfort items • 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, kojí' 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)

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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)