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 deductible?	$0	See the Common Medical Event chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No.	You don't have to meet deductibles for specific services.
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?	Preferred providers: $1,000 individual / $3,000 family per calendar year. Participating & Nonparticipating providers: No limit.	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?	Coinsurance for services from participating and nonparticipating providers, premiums, balance-billing 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.
Will you pay less if you use a network provider?	Yes. See https://regence.com/go/WW/Preferred or call 1 (866) 240-9580 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 participating network. You will pay the most if you use a non-participating 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 non-participating 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.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Non-participating Provider (You pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay / office visit	40% coinsurance after $10 copay / office visit	40% coinsurance after $10 copay / office visit	None
	Specialist visit	$10 copay / office visit	40% coinsurance after $10 copay / office visit	40% coinsurance after $10 copay / office visit	
	Preventive care/screening/ immunization	No charge	No charge	40% coinsurance	No charge for childhood immunizations from nonparticipating providers. 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)	20% coinsurance	40% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Non-participating Provider (You pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://regence.com/go/2024/WW/3tier	Tier 1 (Typically, generic drugs with highest overall value)	Not applicable, refer to participating provider and non-participating provider columns.	No charge / retail prescription; No charge does not apply / home delivery prescription	No charge / retail prescription; No charge / home delivery prescription	Prescription drugs not on the Drug List are not covered, unless an exception is approved. 100-day supply / retail prescription 90-day supply / home delivery prescription 90-day supply / self-injectable drugs 30-day supply / specialty drug prescription Specialty drugs are not available through home delivery. Coverage includes compound medications at 20% coinsurance. Cost shares for insulin will not exceed $35 / 30-day supply retail prescription or $105 / 90-day supply home delivery prescription. No charge for certain preventive drugs, contraceptives and immunizations at a participating pharmacy, or for self-administrable cancer chemotherapy drugs. The first fill of specialty drugs may be provided by a retail pharmacy; additional refills must be provided by a specialty pharmacy.
	Tier 2 (Typically, brand drugs with moderate overall value)	Not applicable, refer to participating provider and non-participating provider columns.	20% coinsurance / retail prescription; 20% coinsurance / home delivery prescription	20% coinsurance / retail prescription; 20% coinsurance / home delivery prescription	
	Tier 3 (Typically, brand drugs with lower overall value)	Not applicable, refer to participating provider and non-participating provider columns.	20% coinsurance / retail prescription; 20% coinsurance / home delivery prescription	20% coinsurance / retail prescription; 20% coinsurance / home delivery prescription	
	Specialty drugs	Not applicable, refer to participating provider and non-participating provider columns.	Refer to tier 1, 2 and 3 drugs above.	Refer to tier 1, 2 and 3 drugs above.	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Non-participating Provider (You pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$30 copay / visit for ambulatory surgery centers; 20% coinsurance for all other facilities	$30 copay / visit for ambulatory surgery centers; 40% coinsurance for all other facilities	$30 copay / visit for ambulatory surgery centers; 40% coinsurance for all other facilities	None
	Physician/surgeon fees	No charge	40% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	Facility: $30 copay / visit Professional: No charge	Facility: $30 copay / visit Professional: No charge	Facility: $30 copay / visit Professional: No charge	Copayment applies to facility charge for each visit (waived if admitted).
	Emergency medical transportation	20% coinsurance	20% coinsurance	20% coinsurance	None
	Urgent care	$10 copay / office visit	40% coinsurance after $10 copay / office visit	40% coinsurance after $10 copay / office visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after $200 copay	40% coinsurance after $200 copay	40% coinsurance after $200 copay	Copayment applies to each inpatient admission; waived if readmitted within 90 days.
	Physician/surgeon fees	No charge	40% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	40% coinsurance	40% coinsurance	None
	Inpatient services	Facility: 20% coinsurance after $200 copay; Professional: No charge	Facility: 40% coinsurance after $200 copay; Professional: 40% coinsurance	Facility: 40% coinsurance after $200 copay; Professional: 40% coinsurance	Copayment applies to each inpatient admission; waived if readmitted within 90 days.
If you are pregnant	Office visits	No charge	40% coinsurance	40% coinsurance	Copayment applies to each inpatient admission; waived if readmitted within 90 days.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Non-participating Provider (You pay the most)	
	Childbirth/delivery professional services	No charge	40% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Childbirth/delivery services for children are not covered.
	Childbirth/delivery facility services	20% coinsurance after $200 copay	40% coinsurance after $200 copay	40% coinsurance after $200 copay	
If you need help recovering or have other special health needs	Home health care	No charge	40% coinsurance	40% coinsurance	130 visits / year
	Rehabilitation services	Facility: 20% coinsurance after $200 copay; Professional: No charge	Facility: 40% coinsurance after $200 copay; Professional: 40% coinsurance	Facility: 40% coinsurance after $200 copay; Professional: 40% coinsurance	Copayment applies to each inpatient admission; waived if readmitted within 90 days. 41 inpatient days / year 40 outpatient visits / year Includes physical therapy, occupational therapy and speech therapy.
	Habilitation services	20% coinsurance	40% coinsurance	40% coinsurance	17 professional neurodevelopmental visits / year Includes physical therapy, occupational therapy and speech therapy.
	Skilled nursing care	No charge	40% coinsurance	40% coinsurance	100 inpatient days / year
	Durable medical equipment	20% coinsurance	40% coinsurance	40% coinsurance	None
	Hospice services	Facility: $200 copay; Professional: No charge	Facility: 40% coinsurance after $200 copay; Professional: No charge	Facility 40% coinsurance after $200 copay; Professional: No charge	Copayment applies to each inpatient admission; waived if readmitted within 90 days. 14 respite inpatient or outpatient 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	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Non-participating Provider (You pay the most)	
	Children's dental check-up	Not covered	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.)

- Bariatric surgery
- Cosmetic surgery, except congenital anomalies
- Dental care
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- 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, 12 visits / year
- Chiropractic care, 10 spinal manipulations / 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.

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	**$0**
Specialist copayment	**$10**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	$0
Copayments	$200
Coinsurance	$800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,060**

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

The plan's overall deductible	**$0**
Specialist copayment	**$10**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	$0
Copayments	$60
Coinsurance	$800
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	**$1,060**

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

The plan's overall deductible	**$0**
Specialist copayment	**$10**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	$0
Copayments	$60
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$360**

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 deductible?	$0	See the Common Vision Event chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not applicable.	See the Common Vision Event chart below for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	See the Common Vision Event chart below for your costs for services this plan covers.
What is the out-of-pocket limit for this plan?	Not applicable.	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not applicable.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. See https://regence.com/go/WW/VSPNetwork or call 1 (844) 299-3041 for a list of VSP doctors.	This plan uses a vision provider network (Vision Service Plan). You will pay less if you use a vision provider in the plan's network. You will pay the most if you use an out-of-network vision provider, and you might receive a bill from a vision provider for the difference between the provider's charge and what your plan pays (balance billing).
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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 provider's office or clinic	Routine vision examination and vision hardware	$10 copay, then no charge up to the VSP doctor limit for adults age 19 and over; No charge up to the VSP doctor limit for children under age 19	$10 copay, then no charge up to the out-of-network provider limit for adults age 19 and over; No charge up to the out-of-network provider limit for children under age 19	For services provided by an out-of-network provider, you pay all charges up front then submit a claim for reimbursement. 1 routine eye examination / calendar year Hardware is limited to 2 pairs of glasses or 1 pair of glasses and 1 supply of contacts every calendar year. The second pair/supply is subject to an additional $10 copay. Coverage for lenses is limited to glass or plastic single vision, lined bifocal (or standard progressive), lined trifocal, lenticular lenses or elective or necessary contacts. For adults age 19 and over: Frames are limited to $65 each from VSP doctors and $35 each from VSP approved vendors. Elective contacts are limited to $65 from VSP doctors and VSP approved vendors. For children under age 19: Frames are limited to $300 each from VSP doctors and $165 each from VSP approved vendors. Elective contacts are limited to $300 from VSP doctors and VSP approved vendors. Examination and vision hardware allowances from an out-of-network providers are limited to: $45 examination, $70 each frame, $30 single vision lens, $50 lined bifocal / standard progressive lens, $65 lined trifocal lens, $100 lenticular lens, $105 elective contacts, or $210 necessary contact lenses.
	Contact lens evaluation and fitting examination	$60 copay	No charge up to the out-of-network provider limit*	For services provided by an out-of-network provider, you pay all charges up front then submit a claim for reimbursement.

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)	
				Coverage is limited to 1 contact lens evaluation and fitting examination every calendar year. *Coverage from an out-of-network provider is included in the elective contact lens or necessary contact lens allowance described above under Routine Vision Examination and Vision Hardware.
	Low vision supplemental examinations (testing)	No charge	No charge up to the out-of-network provider limit	For services provided by an out-of-network provider, you pay all charges up front then submit a claim for reimbursement. $1,000 low vision maximum / 2 calendar years, including supplemental examinations (testing) and care aids 2 supplemental examinations / 2 calendar years Supplemental examinations limited to $125 for out-of-network providers.
	Low vision supplemental care aids	25% coinsurance	25% coinsurance	

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 • 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 and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual identity. Regence does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity or sexual orientation.

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)

VSP provides administration for your Regence vision plan. For VSP vision services, contact:
VSP 1-844-299-3041 (TTY: 1-800-428-4833)

If you believe that Regence or VSP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity or sexual orientation, you can file a grievance with our civil rights coordinator below:

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.

- The Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD).

  Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx

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'dęę', t'áá jiik'eh, éí ná hóló, kojį' 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 ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ 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 ሊያግዝዎት ተዘጋጀተዋል፤ 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 (टिटिवाइ: 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)

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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.

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