



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 (855) 877-0047. 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 (855) 877-0047 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	\$250 individual / \$500 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." "No charge" means \$0 <u>copayment</u> or 0% <u>coinsurance</u> , regardless of <u>deductible</u> applicability.	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-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/WW/Preferred or call 1 (855) 877-0047 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 <u>non-participating 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 <u>non-participating 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 Provider (You pay the least)	Participating Provider (You pay more)	Non-participating 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; No charge for all other services	40% <u>coinsurance</u> after \$20 <u>copay</u> / office visit, <u>deductible</u> does not apply; 40% <u>coinsurance</u> for all other services	50% <u>coinsurance</u> after \$20 <u>copay</u> / office visit, <u>deductible</u> does not apply; 50% <u>coinsurance</u> for all other services	<u>Copayment</u> applies to each office visit only. All other services are covered at the <u>coinsurance</u> specified, after <u>deductible</u> .
	<u>Specialist</u> visit	\$20 <u>copay</u> / office visit, <u>deductible</u> does not apply; No charge for all other services	40% <u>coinsurance</u> after \$20 <u>copay</u> / office visit, <u>deductible</u> does not apply; 40% <u>coinsurance</u> for all other services	50% <u>coinsurance</u> after \$20 <u>copay</u> / office visit, <u>deductible</u> does not apply; 50% <u>coinsurance</u> for all other services	
	<u>Preventive care/screening/immunization</u>	No charge, <u>deductible</u> does not apply	No charge, <u>deductible</u> does not apply	50% <u>coinsurance</u> , <u>deductible</u> does not apply	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.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	40% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	No charge	40% <u>coinsurance</u>	50% <u>coinsurance</u>	

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 <u>prescription drug coverage</u> is available at https://regence.com/go/2025/WW/6tierLG	Tier 1 (Typically, generic drugs with highest overall value)	Not applicable, refer to <u>participating provider</u> and <u>non-participating provider</u> columns.	\$5 <u>copay</u> , <u>deductible</u> does not apply / retail prescription; \$10 <u>copay</u> , <u>deductible</u> does not apply / home delivery prescription	\$5 <u>copay</u> , <u>deductible</u> does not apply / retail prescription; \$10 <u>copay</u> , <u>deductible</u> does not apply / home delivery prescription	<u>Prescription drugs</u> not on the Drug List are not covered, unless an exception is approved. 90-day supply / retail prescription (your <u>cost share</u> is per 30-day supply) 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. The first fill of <u>specialty drugs</u> may be provided by a retail pharmacy; additional refills must be provided by a specialty pharmacy.
	Tier 2 (Typically, generic drugs with moderate overall value)	Not applicable, refer to <u>participating provider</u> and <u>non-participating provider</u> columns.	\$5 <u>copay</u> , <u>deductible</u> does not apply / retail prescription; \$10 <u>copay</u> , <u>deductible</u> does not apply / home delivery prescription	\$5 <u>copay</u> , <u>deductible</u> does not apply / retail prescription; \$10 <u>copay</u> , <u>deductible</u> does not apply / home delivery prescription	
	Tier 3 (Typically, brand drugs with moderate overall value)	Not applicable, refer to <u>participating provider</u> and <u>non-participating provider</u> columns.	\$35 <u>copay</u> , <u>deductible</u> does not apply / retail prescription; \$70 <u>copay</u> , <u>deductible</u> does not apply / home delivery prescription	\$35 <u>copay</u> , <u>deductible</u> does not apply / retail prescription; \$70 <u>copay</u> , <u>deductible</u> does not apply / home delivery prescription	

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)	
	Tier 4 (Typically, brand drugs with lower overall value)	Not applicable, refer to <u>participating provider</u> and <u>non-participating provider</u> columns.	\$60 <u>copay</u> , <u>deductible</u> does not apply / retail prescription; \$120 <u>copay</u> , <u>deductible</u> does not apply / home delivery prescription	\$60 <u>copay</u> , <u>deductible</u> does not apply / retail prescription; \$120 <u>copay</u> , <u>deductible</u> does not apply / home delivery prescription	
	Tier 5 (Typically, <u>specialty drugs</u> with moderate overall value)	Not applicable, refer to <u>participating provider</u> and <u>non-participating provider</u> columns.	\$75 <u>copay</u> , <u>deductible</u> does not apply / <u>specialty drug</u>	\$75 <u>copay</u> , <u>deductible</u> does not apply / <u>specialty drug</u>	
	Tier 6 (Typically, <u>specialty drugs</u> with lower overall value)	Not applicable, refer to <u>participating provider</u> and <u>non-participating provider</u> columns.	\$150 <u>copay</u> , <u>deductible</u> does not apply / <u>specialty drug</u>	\$150 <u>copay</u> , <u>deductible</u> does not apply / <u>specialty drug</u>	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	40% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Physician/surgeon fees	No charge	40% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	10% <u>coinsurance</u> after \$150 <u>copay</u> for facility services; No charge for professional services	10% <u>coinsurance</u> after \$150 <u>copay</u> for facility services; No charge for professional services	10% <u>coinsurance</u> after \$150 <u>copay</u> for facility services; No charge for professional services	<u>Copayment</u> applies to facility charge for each visit (waived if admitted), whether or not the <u>deductible</u> has been met.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	No charge for services related to mental health and substance abuse emergencies.

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)	
	<u>Urgent care</u>	\$20 <u>copay</u> / office visit, <u>deductible</u> does not apply; No charge for all other services	40% <u>coinsurance</u> after \$20 <u>copay</u> / office visit, <u>deductible</u> does not apply; 40% <u>coinsurance</u> for all other services	50% <u>coinsurance</u> after \$20 <u>copay</u> / office visit, <u>deductible</u> does not apply; 50% <u>coinsurance</u> for all other services	<u>Copayment</u> applies to each 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)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Physician/surgeon fees	No charge	40% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% <u>coinsurance</u> for facility services; No charge for professional services	10% <u>coinsurance</u> for facility services; No charge for professional services	50% <u>coinsurance</u>	None
	Inpatient services	10% <u>coinsurance</u> for facility services; No charge for professional services	10% <u>coinsurance</u> for facility services; No charge for professional services	50% <u>coinsurance</u>	
If you are pregnant	Office visits	No charge	40% <u>coinsurance</u>	50% <u>coinsurance</u>	Cost sharing 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	No charge	40% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	

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 help recovering or have other special health needs	<u>Home health care</u>	No charge	40% <u>coinsurance</u>	50% <u>coinsurance</u>	130 visits / year
	<u>Rehabilitation services</u>	10% <u>coinsurance</u> for facility services; 20% <u>coinsurance</u> for outpatient services; No charge for professional services	40% <u>coinsurance</u>	50% <u>coinsurance</u>	40 inpatient days / year 99 outpatient visits / year Includes physical therapy, occupational therapy and speech therapy.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	Includes physical therapy, occupational therapy and speech therapy.
	<u>Skilled nursing care</u>	No charge	No charge	50% <u>coinsurance</u>	100 inpatient days / year
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Hospice services</u>	No charge	No charge	50% <u>coinsurance</u>	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	
	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.)

- | | | |
|---|-------------------------|---|
| • Cosmetic surgery, except congenital anomalies | • Infertility treatment | • Routine eye care |
| • Dental care | • Long-term care | • Routine foot care, except for diabetic patients |
| • Hearing aids | • Private-duty nursing | • Weight loss programs |

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

- | | | |
|---------------------------------|---|--|
| • Abortion | • Bariatric surgery | • Non-emergency care when traveling outside the U.S. |
| • Acupuncture, 12 visits / year | • Chiropractic care, 15 spinal manipulations / year | |

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 (855) 877-0047. 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 (855) 877-0047 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 Office of the Insurance Commissioner of Washington State by calling 1 (800) 562-6900, or through the Internet at: www.insurance.wa.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 (855) 877-0047.

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</u> overall <u>deductible</u>	\$250
■ <u>Specialist</u> <u>copayment</u>	\$20
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	0%

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>	\$250
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$1,100
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$1,420

Managing Joe's Type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$250
■ <u>Specialist</u> <u>copayment</u>	\$20
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	0%

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>	\$250
<u>Copayments</u>	\$700
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$200
The total Joe would pay is	\$1,150

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$250
■ <u>Specialist</u> <u>copayment</u>	\$20
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	0%

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>	\$250
<u>Copayments</u>	\$70
<u>Coinsurance</u>	\$300
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$620

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 (855) 877-0047. 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 (855) 877-0047 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://vsp.com/eye-doctor 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	No charge	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	Not covered	Not covered	None

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	<ul style="list-style-type: none">• Fees, taxes and interest• Low vision benefits• Medical or surgical treatment of the eyes	<ul style="list-style-type: none">• Non-direct patient care• Orthoptics or vision training• Vision hardware

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, sexual orientation or gender identity. Regence does not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation or gender identity.

Regence:

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

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

Provides free language assistance services to people whose primary language is not English, which may include:

- Qualified interpreters
- Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Civil Rights Coordinator.

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, sex, sexual orientation or gender identity, you can file a grievance. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

Customer Service

Civil Rights Coordinator
PO Box 1106
Lewiston, ID 83501-1106
Phone: 1-888-344-6347, (TTY: 711)
Fax: 1-888-309-8784
Email: CS@regence.com

Medicare Customer Service

Phone: 1-800-541-8981 (TTY: 711)
Email: medicareappeals@regence.com

VSP Customer Service

Phone: 1-844-299-3041
TTY: 1-800-428-4833

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

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

You can also file a civil rights complaint with 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/online services/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'déé', t'áá jiik'eh, éí ná hóló, koji' hódíilnih 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 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 ተዘጋጅተዋል፤ የሚከተለው ቁጥር ይደውሉ 1-888-344-6347 (መስማት ለተሳናቸው:- 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, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. 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 فاذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم 711 TTY)