



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?	Tier 1 St. Charles Health System (SCHS) custom <u>network providers</u> : \$500 individual / \$1,500 family per calendar year. Tier 2 in- <u>network providers</u> : \$750 individual / \$2,250 family per calendar year. <u>Out-of-network providers</u> : \$1,000 individual / \$3,000 family per calendar year. The <u>deductible</u> amounts for Tier 1 SCHS custom <u>network providers</u> , Tier 2 in- <u>network providers</u> and <u>out-of-network providers</u> cross accumulate.	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 deductible?	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 deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	Tier 1 SCHS custom <u>network providers</u> : \$3,000 individual / \$9,000 family per calendar year. Tier 2 in- <u>network providers</u> : \$5,000 individual / \$13,200 family per calendar year. <u>Out-of-network providers</u> : \$8,000 individual / \$24,000 family per calendar year. The medical <u>out-of-pocket limit</u> amounts for Tier 1 SCHS custom <u>network providers</u> , Tier 2 in- <u>network providers</u> and <u>out-of-network providers</u> cross accumulate. The pharmacy <u>out-of-pocket limit</u>	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.

	amounts for Tier 1 SCHS custom <u>network providers</u> and Tier 2 in- <u>network providers</u> cross accumulate.	
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> . NOTE: Covered services provided by St. Charles Health System will be covered at a lower <u>cost share</u> unless otherwise stated.	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
		Tier 1 SCHS Custom Network Provider (You will pay the least)	Tier 2 In-Network Provider (You will pay more)	Out-of-Network Provider (You will 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	\$15 <u>copay</u> / office visit, <u>deductible</u> does not apply; 20% <u>coinsurance</u> , <u>deductible</u> does not apply for expanded office services; 20% <u>coinsurance</u> , <u>deductible</u> does not apply* for other services	\$35 <u>copay</u> / office visit, <u>deductible</u> does not apply; 30% <u>coinsurance</u> , <u>deductible</u> does not apply for expanded office services; 30% <u>coinsurance</u> , <u>deductible</u> does not apply* for other services	50% <u>coinsurance</u>	Expanded office services include medical/surgical services, therapeutic injections, and diagnostic procedures. * <u>Deductible</u> applies for Tier 1 SCHS custom <u>network providers</u> and Tier 2 in- <u>network providers</u> office services for vasectomies, footcare associated with diabetes, termination of pregnancy, PKU and biofeedback.
	<u>Specialist</u> visit	\$25 <u>copay</u> / office visit, <u>deductible</u> does not apply;	\$50 <u>copay</u> / office visit, <u>deductible</u> does not apply;	50% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 SCHS Custom Network Provider (You will pay the least)	Tier 2 In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
		20% <u>coinsurance</u> , <u>deductible</u> does not apply for expanded office services; 20% <u>coinsurance</u> , <u>deductible</u> does not apply* for other services	30% <u>coinsurance</u> , <u>deductible</u> does not apply for expanded office services; 30% <u>coinsurance</u> , <u>deductible</u> does not apply* for 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>	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)	20% <u>coinsurance</u> , <u>deductible</u> does not apply for outpatient services	30% <u>coinsurance</u> *	50% <u>coinsurance</u>	* <u>Deductible</u> does not apply for Tier 2 in- <u>network providers</u> outpatient services for office visits, independent laboratory or x-ray facility place of imaging.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u> , <u>deductible</u> does not apply for outpatient services	30% <u>coinsurance</u> *	50% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 SCHS Custom Network Provider (You will pay the least)	Tier 2 In-Network Provider (You will pay more)	Out-of-Network Provider (You will 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/2026/OR/4tierLGStd .	Tier 1 (Typically, generic drugs with highest overall value)	\$5 <u>copay</u> , <u>deductible</u> does not apply / 30-day retail prescription; \$12.50 <u>copay</u> , <u>deductible</u> does not apply / 90-day retail prescription	\$10 <u>copay</u> , <u>deductible</u> does not apply / 30-day retail prescription; \$20 <u>copay</u> , <u>deductible</u> does not apply / home delivery prescription	60% <u>coinsurance</u> / 30-day retail prescription; 60% <u>coinsurance</u> / 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 for St. Charles Health System pharmacies; 30-day supply / retail prescription for all other pharmacies. 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. No charge, <u>deductible</u> does not apply for certain preventive drugs, contraceptives and immunizations at a participating pharmacy. 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>. 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, brand drugs with moderate overall value)	\$30 <u>copay</u> , <u>deductible</u> does not apply / 30-day retail prescription; \$75 <u>copay</u> , <u>deductible</u> does not apply / 90-day retail prescription	\$40 <u>copay</u> , <u>deductible</u> does not apply / 30-day retail prescription; \$80 <u>copay</u> , <u>deductible</u> does not apply / home delivery prescription	60% <u>coinsurance</u> / 30-day retail prescription; 60% <u>coinsurance</u> / home delivery prescription	
	Tier 3 (Typically, brand drugs with lower overall value)	\$50 <u>copay</u> , <u>deductible</u> does not apply / 30-day retail prescription; \$125 <u>copay</u> , <u>deductible</u> does not apply / 90-day retail prescription	\$60 <u>copay</u> , <u>deductible</u> does not apply / 30-day retail prescription; \$120 <u>copay</u> , <u>deductible</u> does not apply / home delivery prescription	60% <u>coinsurance</u> / 30-day retail prescription; 60% <u>coinsurance</u> / home delivery prescription	
	Tier 4 (<u>Specialty drugs</u>)	\$100 <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>	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 SCHS Custom Network Provider (You will pay the least)	Tier 2 In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copay</u> / visit, <u>deductible</u> does not apply	\$100 <u>copay</u> / visit, <u>deductible</u> does not apply	\$100 <u>copay</u> / visit, <u>deductible</u> does not apply	<u>Copayment</u> applies to facility charge for each visit (waived if admitted).
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u> , <u>deductible</u> does not apply for ground transportation; No charge, <u>deductible</u> does not apply for air transportation	20% <u>coinsurance</u> , <u>deductible</u> does not apply for ground transportation; No charge, <u>deductible</u> does not apply for air transportation	20% <u>coinsurance</u> , <u>deductible</u> does not apply for ground transportation; No charge, <u>deductible</u> does not apply for air transportation	None
	<u>Urgent care</u>	\$15 <u>copay</u> / visit, <u>deductible</u> does not apply; 20% <u>coinsurance</u> , <u>deductible</u> does not apply for other services	\$50 <u>copay</u> / visit, <u>deductible</u> does not apply; 30% <u>coinsurance</u> , <u>deductible</u> does not apply for other services	30% <u>coinsurance</u> / visit, <u>deductible</u> does not apply; 50% <u>coinsurance</u> for other services	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 SCHS Custom Network Provider (You will pay the least)	Tier 2 In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 <u>copay</u> / office or psychotherapy visit, <u>deductible</u> does not apply; \$15 <u>copay</u> , <u>deductible</u> does not apply for other services	\$15 <u>copay</u> / office or psychotherapy visit, <u>deductible</u> does not apply; \$15 <u>copay</u> , <u>deductible</u> does not apply for other services	50% <u>coinsurance</u>	None
	Inpatient services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you are pregnant	Office visits	20% <u>coinsurance</u>	30% <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	20% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge, <u>deductible</u> does not apply	No charge, <u>deductible</u> does not apply	50% <u>coinsurance</u>	130 visits / year
	<u>Rehabilitation services</u>	\$25 <u>copay</u> / outpatient visit, <u>deductible</u> does not apply; 20% <u>coinsurance</u> for inpatient services	\$25 <u>copay</u> / outpatient visit, <u>deductible</u> does not apply; 30% <u>coinsurance</u> for inpatient services	50% <u>coinsurance</u>	50 outpatient visits / year combined with neurodevelopmental therapy Includes physical therapy, occupational therapy and speech therapy.
	<u>Habilitation services</u>	\$25 <u>copay</u> / visit, <u>deductible</u> does not apply	\$25 <u>copay</u> / visit, <u>deductible</u> does not apply	50% <u>coinsurance</u>	50 neurodevelopmental visits / year combined with outpatient rehabilitation services Includes physical therapy, occupational therapy and speech therapy.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 SCHS Custom Network Provider (You will pay the least)	Tier 2 In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	100 inpatient days / year
	<u>Durable medical equipment</u>	20% <u>coinsurance</u> , <u>deductible</u> does not apply	20% <u>coinsurance</u> , <u>deductible</u> does not apply	50% <u>coinsurance</u>	\$500 for wigs / lifetime
	<u>Hospice services</u>	No charge, <u>deductible</u> does not apply	No charge, <u>deductible</u> does not apply	No charge, <u>deductible</u> does not apply	15 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 | • Long-term care | • Routine foot care, except for diabetic patients |
| • Dental care | • Private-duty nursing | • Weight loss programs |
| • Infertility treatment | • Routine eye care | |

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

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|---|---|--|
| • Abortion | • Bariatric surgery, \$250,000 / lifetime | • Hearing aids, \$4,000 / 5 years |
| • Acupuncture, \$1,500 / year for all acupuncture and spinal manipulation visits combined | • Chiropractic care, \$1,500 / year for all acupuncture and spinal manipulation visits combined | • 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 (Coverage examples included below are calculated based on in-network benefits):



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>	\$750
■ <u>Specialist</u> <u>copayment</u>	\$50
■ Hospital (facility) <u>coinsurance</u>	30%
■ Other <u>coinsurance</u>	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>	\$750
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$3,400
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$4,220

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>	\$750
■ <u>Specialist</u> <u>copayment</u>	\$50
■ Hospital (facility) <u>coinsurance</u>	30%
■ Other <u>coinsurance</u>	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>	\$750
<u>Copayments</u>	\$900
<u>Coinsurance</u>	\$40
What isn't covered	
Limits or exclusions	\$200
The total Joe would pay is	\$1,890

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$750
■ <u>Specialist</u> <u>copayment</u>	\$50
■ Hospital (facility) <u>coinsurance</u>	30%
■ Other <u>coinsurance</u>	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>	\$400
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$300
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,100

The plan would be responsible for the other costs of these EXAMPLE covered services.

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 less favorably because of race, color, national origin, age, disability, or sex.

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, or sex, 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>.

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)::

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, 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: 711)