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/go/policy/2018/OR/BronzeEssential7150EPO or call 1 (888) 675-6570. 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) 675-6570 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $7,150 individual / $14,300 family per calendar year. Out-of-network: Not applicable	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Certain prescription drugs, pediatric dental services, pediatric vision services and the following in-network services: preventive care and upfront office and urgent care visits.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at healthcare.gov/coverage/preventive-care-benefits/.
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?	In-network: $7,350 individual / $14,700 family per calendar year. Out-of-network: Not applicable	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?	Premiums, balance-billed charges, coinsurance for out-of-network pediatric vision services, 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 regence.com/go/IFN or call 1 (888) 675-6570 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network 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 an out-of-network 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.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$60 copay / visit, deductible does not apply; other services 10% coinsurance	Not covered	Copayment applies to each in-network upfront office visit only (limit of 2 upfront primary care or specialist visits or urgent care facility visits / year combined). Once the limit has been met and for all other services that are not billed as an office visit, services are covered at the coinsurance specified, after deductible.
	Specialist visit	$60 copay / visit, deductible does not apply; other services 10% coinsurance	Not covered	
	Preventive care/screening/ immunization	No charge	Not covered	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)	10% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	Not covered	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at regence.com/go/formulary/2018/6tierEssential.	Generic drugs (preferred & non-preferred)	$15 copay* / preferred retail prescription $30 copay / preferred mail order prescription 10% coinsurance* / non-preferred retail prescription 5% coinsurance / non-preferred mail order prescription		No coverage for prescription drugs not on the Essential Formulary. No coverage for prescription drugs from an out-of-network pharmacy. Limited to a 90-day supply retail (1 copayment per 30-day supply), 90-day supply mail order or 30-day supply self-administrable cancer chemotherapy and specialty drugs. No charge for FDA-approved women's contraceptives and certain preventive drugs and immunizations at a participating pharmacy. Deductible waived for preferred generic drugs. The first fill for specialty drugs may be provided at a retail pharmacy. Additional refills of specialty drugs, and any first fill and additional refills for specialty self-administrable
	Preferred brand drugs	10% coinsurance* / retail prescription 5% coinsurance / mail order prescription		
	Non-preferred brand drugs	50% coinsurance* / retail prescription 45% coinsurance / mail order prescription		
	Specialty drugs (preferred & non-preferred)	40% coinsurance / preferred retail prescription 50% coinsurance / non-preferred retail prescription		

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
				cancer chemotherapy drugs and some specialty drugs must be provided at a specialty pharmacy. Coverage for self-administrable cancer chemotherapy drugs is 10% coinsurance. *Discount of $5 off copayment or 5% off coinsurance when filled at a preferred retail pharmacy
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered	None
	Physician/surgeon fees	10% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	In-network deductible applies to in-network and out-of-network services.
	Emergency medical transportation	10% coinsurance	10% coinsurance	In-network deductible applies to in-network and out-of-network services.
	Urgent care	$60 copay / visit, deductible does not apply; other services 10% coinsurance	Not covered	Copayment applies to each in-network upfront office visit only (limit of 2 upfront urgent care facility visits, primary care or specialist visits / year combined). Once the limit has been met and for all other services that are not billed as an office visit, services are covered at the coinsurance specified, after deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not covered	None
	Physician/surgeon fees	10% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	Not covered	None
	Inpatient services	10% coinsurance	Not covered	None
If you are pregnant	Office visits	10% coinsurance	Not covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, a coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	Not covered	
	Childbirth/delivery facility services	10% coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Not covered	None
	Rehabilitation services	10% coinsurance	Not covered	Limited to 30 inpatient days (up to 60 days for head or spinal cord injury) and 30 outpatient visits each for rehabilitation and habilitation services / year. Includes physical therapy, speech therapy, and occupational therapy.
	Habilitation services	10% coinsurance	Not covered	
	Skilled nursing care	10% coinsurance	Not covered	Limited to 60 inpatient days / year.
	Durable medical equipment	10% coinsurance	Not covered	Limited to 1 synthetic wig / year and 1 pair of glasses or contacts / year due to severe medical or surgical problem other than refractive procedures.
	Hospice services	10% coinsurance	Not covered	Limited to 30 inpatient or outpatient respite days / lifetime (limited to a maximum of 5 consecutive respite days at a time).
If your child needs dental or eye care	Children's eye exam	No charge	50% coinsurance, deductible does not apply	Limited to 1 routine exam / year for individuals under age 19. Coinsurance for out-of-network services does not apply to the out-of-pocket limit.
	Children's glasses	No charge	50% coinsurance, deductible does not apply	Limited to 1 pair of lenses (2 lenses) and 1 frame / year for individuals under age 19. Frames from a VSP Doctor are limited to the Otis & Piper Eyewear Collection. Coinsurance for out-of-network services does not apply to the out-of-pocket limit.
	Children's dental check-up	No charge	No charge	Limited to 2 cleanings and 2 preventive oral examinations / year for individuals under age 19. Additional coverage is provided for basic and major pediatric dental services.

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.)		
• Acupuncture	• Dental care (Adult)	• Private-duty nursing
• Bariatric surgery	• Infertility treatment	• Routine eye care, including vision hardware (Adult)
• Chiropractic care	• Long-term care	• Routine foot care, except for diabetic patients
• Cosmetic surgery, except for certain situations	• Non-emergency care when traveling outside the U.S.	• 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.)	
• Abortion	• Hearing aids

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 cciio.cms.gov or your state insurance department. You may also contact the plan at 1 (888) 675-6570. 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) 675-6570 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: cp.ins@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) 675-6570.

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	$7,150
Specialist copayment	$60
Hospital (facility) coinsurance	10%
Other coinsurance	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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$7,150
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$7,410**

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

The plan's overall deductible	$7,150
Specialist copayment	$60
Hospital (facility) coinsurance	10%
Other coinsurance	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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$5,412
Copayments	$749
Coinsurance	$0
What isn't covered	
Limits or exclusions	$255
The total Joe would pay is	**$6,416**

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

The plan's overall deductible	$7,150
Specialist copayment	$60
Hospital (facility) coinsurance	10%
Other coinsurance	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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,636
Copayments	$261
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,897**

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

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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/go/policy/2018/OR/AdultDVIAP or call 1 (888) 675-6570. 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) 675-6570 to request a copy.

Dental Coverage

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$50 individual / $150 family per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive dental services.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
Is there an overall annual limit on what the plan pays?	Yes. $750 / individual per calendar year. An additional dollar amount will be added to the annual limit if Rewards program requirements are met.	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart below describes *specific* coverage limits.
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 regence.com/go/StandardDental or call 1 (888) 675-6570 for a list of network providers.	This plan uses a participating dental provider network. You pay less if you use a participating dental provider. You will pay the most if you use a nonparticipating dental provider, and you might receive a bill from a nonparticipating dental 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.

All coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Dental Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Nonparticipating Provider (You will pay the most)	
If you have preventive dental services	Cleanings and examinations	No charge	No charge	Limited to 2 cleanings and 2 preventive oral examinations / year.
	X-rays	No charge	No charge	Limited to 2 bitewing x-ray series / year. Limited to 1 complete intra-oral mouth and 1 panoramic mouth x-ray once in a 3-year period.
If you need basic dental services	Periodontal services	20% coinsurance	20% coinsurance	Subject to a 6-month waiting period for all basic dental services. Limited to 2 periodontal maintenance / year (in lieu of preventive cleanings). Limited to 1 periodontal debridement in a 3-year period. Limited to 1 per quadrant in a 2-year period for periodontal scaling and root planing.
	Endodontic services	20% coinsurance	20% coinsurance	None
	Emergency and other basic dental services	20% coinsurance	20% coinsurance	None
If you need major dental services	Bridges	50% coinsurance	50% coinsurance	Subject to a 12-month waiting period for all major dental services. Limited to replacement bridges once per 7 years after placement.
	Crowns, inlays and onlays	50% coinsurance	50% coinsurance	Limited to replacement crowns, inlays or onlays once per tooth, 7 years after placement.
	Dentures (full and partial)	50% coinsurance	50% coinsurance	Limited to replacement dentures 7 years after placement.
	Implants (endosteal)	50% coinsurance	50% coinsurance	Limited to 4 endosteal implants / lifetime.

Excluded Dental 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.)		
• Aesthetic dental procedures • Cosmetic/reconstructive services and supplies, except congenital anomalies • Duplicate x-rays • Facility charges • Gold-foil restorations	• Implants (non-endosteal) • Nitrous oxide • Occlusal treatment • Orthodontic services • Orthognathic surgery	• Pediatric Dental (under age 19) • Prescription Medications • Temporomandibular joint (TMJ) dysfunction treatment • Tooth transplantation • Veneers

Vision Coverage

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Vision Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not applicable.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
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?	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 regence.com/go/VSPNetwork or call 1 (800) 877-7195 for lists of VSP doctors or out-of-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from an out-of-network 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	Out-of-network Provider	
If you visit a vision care provider's office or clinic	Routine vision examination and vision hardware	No charge up to the VSP doctor limit	No charge up to the out-of-network provider limit	Limited to individuals age 19 or older. Routine examination limited to 1 every calendar year, and limited to $45 for an out-of-network provider. Frame or elective contact lenses* limited to $150 from a VSP doctor / every calendar year; frame allowance limited to $80 from a VSP approved wholesale/retail vendor; and $70 from an out-of-network provider / every calendar year. 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. Lenses from an out-of-network provider limited to: $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)*. *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.
	Contact lens evaluation and fitting examination	$60 copay	No charge up to the out-of-network provider limit	Limited to individuals age 19 or older. 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.

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 out-of-network provider limit	Limited to individuals age 19 or older. Supplemental testing allowance limited to $125 for out-of-network providers. Supplemental testing and supplemental aids limited to a combined maximum of $1,000 once every 2 calendar years.
	Low vision supplemental 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, interest
- Medical or surgical treatment of the eyes
- Non-direct patient care
- Orthoptics or vision training
- 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:

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'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)

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