



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/go/2021/policy/UT/BronzeEssential7500EPOIFNEx> or call 1 (888) 231-8424. 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) 231-8424 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|---|
| What is the overall <u>deductible</u>? | \$7,500 individual / \$15,000 family per calendar year. | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . |
| Are there services covered before you meet your <u>deductible</u>? | Yes. Certain <u>preventive care</u> and those services listed below as " <u>deductible</u> does not apply" or as "No charge." | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other <u>deductibles</u> for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u>? | \$8,550 individual / \$17,100 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/UT/IFN or call 1 (888) 231-8424 for a list of <u>network providers</u> . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from 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 |
|--|--|---|--|--|
| | | 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 <u>copay</u> / office visit, <u>deductible</u> does not apply; 10% <u>coinsurance</u> for all other services | Not covered | 4 in- <u>network</u> upfront office visits / year <u>Copayment</u> applies to each in- <u>network</u> upfront office visit only. All other services and after the upfront visit limit is met, services are covered at the <u>coinsurance</u> specified, after <u>deductible</u> . Retail clinic visits do not apply to upfront visit limit. Coverage includes primary care visits at a retail clinic. |
| | <u>Specialist</u> visit | \$60 <u>copay</u> / office visit, <u>deductible</u> does not apply; 10% <u>coinsurance</u> for all other services | Not covered | |
| | <u>Preventive care/screening/immunization</u> | No charge | Not covered | |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | 10% <u>coinsurance</u> | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | 10% <u>coinsurance</u> | Not covered | |
| 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/2021/UT/6tier | Preferred generic drugs & generic drugs | \$15 <u>copay</u> / preferred retail prescription \$30 <u>copay</u> / preferred mail order prescription 10% <u>coinsurance</u> / retail prescription 5% <u>coinsurance</u> / mail order prescription 10% <u>coinsurance</u> / self-administrable cancer chemotherapy retail and mail order prescription | Not covered | No coverage for <u>prescription drugs</u> not on the Drug List. <u>Deductible</u> does not apply for preferred generic and generic drugs and drugs specifically designated as preventive for treatment of chronic diseases that are on the Optimum Value Medication List. 90-day supply / retail prescription (your <u>cost share</u> is per 30-day supply) 90-day supply / mail order prescription 30-day supply / <u>specialty drug</u> retail prescription or self-administrable cancer chemotherapy drugs <u>Cost shares</u> for preferred brand insulin will not exceed \$30 / 30-day supply retail prescription or \$60 / 90-day supply mail order prescription, whether or not any applicable <u>deductible</u> has been met. No charge for certain preventive drugs, women's |
| | Preferred brand drugs | 20% <u>coinsurance</u> / retail prescription 15% <u>coinsurance</u> / mail order prescription | 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) | |
| | | 10% <u>coinsurance</u> / self-administrable cancer chemotherapy retail and mail order prescription | | <p>contraceptives and immunizations at a participating pharmacy.</p> <p>The first fill of <u>specialty drugs</u> may be provided by a retail pharmacy; additional refills must be provided by a specialty pharmacy.</p> <p>The first fill of <u>specialty drugs</u> for hemophilia may be provided by a retail pharmacy; additional fills must be provided by a specialty pharmacy or a specialty pharmacy designated as a hemophilia treatment center.</p> <p>Medications used as part of an outpatient cancer drug treatment regimen that is provided and dispensed in a professional setting will be subject to these prescription benefits.</p> |
| | Brand drugs | 50% <u>coinsurance</u> / retail prescription 45% <u>coinsurance</u> / mail order prescription 10% <u>coinsurance</u> / self-administrable cancer chemotherapy retail and mail order prescription | Not covered | |
| | Preferred <u>specialty drugs</u> & <u>specialty drugs</u> | 40% <u>coinsurance</u> / preferred retail prescription 50% <u>coinsurance</u> / retail prescription 10% <u>coinsurance</u> / self-administrable cancer chemotherapy retail and mail order prescription | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 10% <u>coinsurance</u> | Not covered | None |
| | Physician/surgeon fees | 10% <u>coinsurance</u> | Not covered | |
| If you need immediate medical attention | <u>Emergency room care</u> | 10% <u>coinsurance</u> | 10% <u>coinsurance</u> | In- <u>network</u> and out-of- <u>network</u> services apply to the in- <u>network deductible</u> . |
| | <u>Emergency medical transportation</u> | 10% <u>coinsurance</u> | 10% <u>coinsurance</u> | |
| | <u>Urgent care</u> | \$60 <u>copay</u> / office visit, <u>deductible</u> does not apply; 10% <u>coinsurance</u> for all other services | Not covered | <p>4 in-<u>network</u> upfront office visits / year.</p> <p><u>Copayment</u> applies to each in-<u>network</u> upfront office visit only. All other services and after the upfront visit limit is met, services are covered at the <u>coinsurance</u> specified, after <u>deductible</u>.</p> <p>Retail clinic visits do not apply to upfront visit limit.</p> |

| 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 have a hospital stay | Facility fee (e.g., hospital room) | 10% <u>coinsurance</u> | Not covered | None |
| | Physician/surgeon fees | 10% <u>coinsurance</u> | Not covered | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 10% <u>coinsurance</u> | Not covered | None |
| | Inpatient services | 10% <u>coinsurance</u> | Not covered | None |
| If you are pregnant | Office visits | 10% <u>coinsurance</u> | Not covered | Adoption coverage is paid at the in- <u>network</u> benefit, limited to \$4,000 / pregnancy. The adoption indemnity benefit is not exchangeable for infertility treatment benefits. <u>Cost sharing</u> 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 | 10% <u>coinsurance</u> | Not covered | |
| | Childbirth/delivery facility services | 10% <u>coinsurance</u> | Not covered | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 10% <u>coinsurance</u> | Not covered | 30 visits / year |
| | <u>Rehabilitation services</u> | 10% <u>coinsurance</u> | Not covered | 30 inpatient days / year for rehabilitation and skilled nursing care combined 20 outpatient visits combined / year Includes physical therapy, occupational therapy and speech therapy. |
| | <u>Habilitation services</u> | 10% <u>coinsurance</u> | Not covered | 30 inpatient days and 20 outpatient visits combined / year Includes physical therapy, occupational therapy and speech therapy. |
| | <u>Skilled nursing care</u> | 10% <u>coinsurance</u> | Not covered | 30 inpatient days / year for rehabilitation and skilled nursing care combined |
| | <u>Durable medical equipment</u> | 10% <u>coinsurance</u> | Not covered | None |
| | <u>Hospice services</u> | 10% <u>coinsurance</u> | Not covered | 14 respite inpatient or outpatient days / lifetime |
| | Children's eye exam | No charge for VSP doctor | Not covered | 1 routine eye examination / year for individuals under age 19 |

| 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) | |
| | Children's glasses | No charge* for VSP doctor | Not covered | 1 pair of lenses / year 1 set of frames / year Glasses limited to individuals under age 19. *Frames limited to Otis & Piper Eyewear Collection. |
| | Children's dental check-up | No charge | Not covered | 2 cleanings* / year 2 preventive oral examinations / year Coverage limited to individuals under age 19. *Coverage may include another cleaning, refer to your <u>plan</u> for further information. |

Excluded Services & Other Covered Services:

Exclusion Examples

The following examples of limitations and exclusions are included to illustrate the types of conditions, treatments, services, supplies or accommodations that may not be covered under your plan, including related secondary medical conditions and are not all inclusive:

- charges in connection with reconstructive or plastic surgery that may have limited benefits, such as a chemical peel that does not alleviate a functional impairment;
- complications relating to services and supplies for, or in connection with, gastric or intestinal bypass, gastric stapling, or other similar surgical procedure to facilitate weight loss, or for, or in connection with, reversal or revision of such procedures, or any direct complications or consequences thereof;
- complications by infection from a cosmetic procedure, except in cases of reconstructive surgery:
 - when the service is incidental to or follows a surgery resulting from trauma, infection or other diseases of the involved part; or
 - related to a congenital disease or anomaly of a covered child that has resulted in functional defect; or
- complications that result from an injury or illness resulting from active participation in illegal activities.

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- | | | |
|--|-------------------------|---|
| • Abortion (except in cases of rape, incest or to avert the death of the mother) | • Dental care (Adult) | • Private-duty nursing |
| • Acupuncture | • Hearing aids | • Routine eye care (Adult) |
| • Bariatric surgery | • Infertility treatment | • Routine foot care, except for diabetic patients |
| • Cosmetic surgery, except congenital anomalies | • Long-term care | • Weight loss programs |

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

- | | |
|--|--|
| • Chiropractic care, spinal manipulations only | • 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 ccio.cms.gov or your state insurance department. You may also

contact the plan at 1 (888) 231-8424. 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) 231-8424 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 Utah Department of Insurance by calling 1 (801) 538-3077 or the toll-free message line at 1 (800) 439-3805; by writing to the Utah Department of Insurance, State Office Building Suite 3110, Salt Lake City, UT 84114-6901; through the Internet at: www.insurance.utah.gov; or by E-mail at: healthappeals.uid@utah.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:

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1 (888) 231-8424.

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> | \$7,500 |
| ■ <u>Specialist</u> <u>copayment</u> | \$60 |
| ■ Hospital (facility) <u>coinsurance</u> | 10% |
| ■ Other <u>coinsurance</u> | 10% |

This **EXAMPLE** event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$7,500 |
| <u>Copayments</u> | \$11 |
| <u>Coinsurance</u> | \$472 |
| What isn't covered | |
| Limits or exclusions | \$61 |
| The total Peg would pay is | \$8,044 |

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> | \$7,500 |
| ■ <u>Specialist</u> <u>copayment</u> | \$60 |
| ■ Hospital (facility) <u>coinsurance</u> | 10% |
| ■ Other <u>coinsurance</u> | 10% |

This **EXAMPLE** event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$877 |
| <u>Copayments</u> | \$499 |
| <u>Coinsurance</u> | \$625 |
| What isn't covered | |
| Limits or exclusions | \$178 |
| The total Joe would pay is | \$2,179 |

Mia's Simple Fracture

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

| | |
|---|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$7,500 |
| ■ <u>Specialist</u> <u>copayment</u> | \$60 |
| ■ Hospital (facility) <u>coinsurance</u> | 10% |
| ■ Other <u>coinsurance</u> | 10% |

This **EXAMPLE** event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$2,090 |
| <u>Copayments</u> | \$425 |
| <u>Coinsurance</u> | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,515 |

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 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'déé', t'áá jiik'eh, éí ná hóló, koji' 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 ដោយមិនគិតល្បួល គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 1-888-344-6347 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-344-6347 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-888-344-6347 (TTY: 711)

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል፤ በሚከተለው ቁጥር ይደውሉ 1-888-344-6347 (መስማት ለተሳናቸው:- 711)።

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-344-6347 (телетайп: 711)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-344-6347 (टिक्टाइप: 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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