



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, [ProvidenceHealthPlan.com](http://ProvidenceHealthPlan.com). For 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](http://healthcare.gov/sbc-glossary) or call 1-800-878-4445 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<a href="#">In-Network</a> : \$5,500 person / \$11,000 family (2 or more).	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Most <a href="#">preventive care in-network</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="http://healthcare.gov/coverage/preventive-care-benefits/">healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet deductibles for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<a href="#">In-Network</a> : \$9,200 person / \$18,400 family (2 or more).	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance billing</a> , penalties, chiropractic manipulation, acupuncture, services not covered, fees above <a href="#">Usual, Customary and Reasonable (UCR)</a> .	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://ProvidenceHealthPlan.com/findaprovider">ProvidenceHealthPlan.com/findaprovider</a> or call 1-800-878-4445 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)  
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)



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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's office</a> or clinic</b>	Primary care visit to treat an injury or illness	First 3 visits \$5 <a href="#">copay</a> /per visit; <a href="#">deductible</a> does not apply then \$40 <a href="#">copay</a> /per in-person visit; <a href="#">deductible</a> does not apply or \$40 <a href="#">copay</a> /per virtual visit; <a href="#">deductible</a> does not apply	Not covered	Some services such as lab and x-ray will include additional member costs. Providence ExpressCare phone and video visits are covered in full <a href="#">in-network</a> . \$5 copay applies to the first three Primary Care Provider and/or behavioral health outpatient visits combined.
	<a href="#">Specialist</a> visit	\$80 <a href="#">copay</a> /per visit; <a href="#">deductible</a> does not apply	Not covered	Some services such as lab and x-ray will include additional member costs.
	<a href="#">Preventive care/screening/immunization</a>	No charge; <a href="#">deductible</a> does not apply	Not covered	Not all <a href="#">preventive services</a> are required to be covered in full by the ACA. For more information on <a href="#">preventive services</a> that are covered in full see: <a href="#">ProvidenceHealthPlan.com/PreventiveCare</a> . 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.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	30% <a href="#">coinsurance</a>	Not covered	None
	Imaging (CT/PET scans, MRIs)	30% <a href="#">coinsurance</a>	Not covered	<a href="#">Prior authorization</a> required. If you do not obtain <a href="#">Prior authorization</a> claims for those services will be denied and you will be responsible for payment of those services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="#">ProvidenceHealthPlan.com</a>	Tier 1 drugs	\$15 <a href="#">copay</a> /per 30 day supply retail; <a href="#">deductible</a> does not apply	Not covered	ACA Preventive drugs are covered in full <a href="#">in-network</a> . Covers up to a 30-day supply (retail); 90-day mail-order supply covered at 2 times the retail <a href="#">copay</a> or 5% less than the retail <a href="#">coinsurance</a> . <a href="#">Prior authorization</a> may apply. If you do not obtain <a href="#">Prior authorization</a> claims for those services will be denied and you will be responsible for payment of those services. If a brand-name drug is requested when a generic is available, you will pay the difference in cost, plus your Tier 4 or Tier 6 cost-share. <a href="#">Specialty drugs</a> (listed in Tier 5 and Tier 6 on your formulary) can only be purchased at a participating specialty pharmacy (limited to 30 days).
	Tier 2 drugs	\$15 <a href="#">copay</a> /per 30 day supply retail; <a href="#">deductible</a> does not apply	Not covered	
	Tier 3 drugs	\$60 <a href="#">copay</a> /per 30 day supply retail; <a href="#">deductible</a> does not apply	Not covered	
	Tier 4 drugs	50% <a href="#">coinsurance</a> retail; <a href="#">deductible</a> does not apply	Not covered	
	Tier 5 drugs	50% <a href="#">coinsurance</a> retail; <a href="#">deductible</a> does not apply	Not covered	
	Tier 6 drugs	50% <a href="#">coinsurance</a> retail; <a href="#">deductible</a> does not apply	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	30% <a href="#">coinsurance</a>	Not covered	<a href="#">Prior authorization</a> required. If you do not obtain <a href="#">Prior authorization</a> claims for those services will be denied and you will be responsible for payment of those services.
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	Not covered	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	For <a href="#">emergency medical conditions</a> only. If admitted to hospital, all services subject to inpatient benefits.
	<a href="#">Emergency medical transportation</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
	<a href="#">Urgent care</a>	\$70 <a href="#">copay</a> /per visit; <a href="#">deductible</a> does not apply <a href="#">in-network</a>	\$70 <a href="#">copay</a> /per visit	Some services will include additional member costs.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	30% <a href="#">coinsurance</a>	Not covered	<a href="#">Prior authorization</a> required. If you do not obtain <a href="#">Prior authorization</a> claims for those services will be denied and you will be responsible for payment of those services.
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: First 3 visits \$5 <a href="#">copay</a> /per visit; <a href="#">deductible</a> does not apply then \$40 <a href="#">copay</a> /per in-person visit; <a href="#">deductible</a> does not apply or \$40 <a href="#">copay</a> /per virtual visit; <a href="#">deductible</a> does not apply All other services: 30% <a href="#">coinsurance</a>	Not covered	All services except <a href="#">provider</a> office visits must be <a href="#">prior authorized</a> . If you do not obtain <a href="#">Prior authorization</a> claims for those services will be denied and you will be responsible for payment of those services. See your benefit summary for Applied Behavioral Analysis (ABA) services. \$5 copay applies to the first three Primary Care Provider and/or behavioral health outpatient visits combined.
	Inpatient services	30% <a href="#">coinsurance</a>	Not covered	
If you are pregnant	Office visits	No charge; <a href="#">deductible</a> does not apply	Not covered	None
	Childbirth/delivery professional services	30% <a href="#">coinsurance</a>	Not covered	<a href="#">Coinsurance</a> applies to provider delivery charges.
	Childbirth/delivery facility services	30% <a href="#">coinsurance</a>	Not covered	None
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	30% <a href="#">coinsurance</a>	Not covered	<a href="#">Prior authorization</a> required. If you do not obtain <a href="#">Prior authorization</a> claims for those services will be denied and you will be responsible for payment of those services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<a href="#">Rehabilitation services</a>	Inpatient: 30% <a href="#">coinsurance</a> Outpatient - Physical Therapy: \$40 <a href="#">copay</a> /per visit; <a href="#">deductible</a> does not apply Outpatient - Occupational & Speech Therapy: \$40 <a href="#">copay</a> /per visit; <a href="#">deductible</a> does not apply	Not covered	Inpatient services: Limited to 30 days for <a href="#">in-network providers</a> per calendar year. Limited to 60 days for <a href="#">in-network providers</a> per calendar year for head/spinal injuries. <a href="#">Prior authorization</a> required. If you do not obtain <a href="#">Prior authorization</a> claims for those services will be denied and you will be responsible for payment of those services. Outpatient services: Limited to 30 visits for <a href="#">in-network providers</a> per calendar year. Additional visits per specified condition: Limited to 30 visits for <a href="#">in-network providers</a> per calendar year. Limits do not apply to Mental Health and Substance Use Disorder Services.
	<a href="#">Habilitation services</a>	Inpatient: 30% <a href="#">coinsurance</a> Outpatient: \$40 <a href="#">copay</a> /per visit; <a href="#">deductible</a> does not apply	Not covered	Inpatient services: Limited to 30 days for <a href="#">in-network providers</a> per calendar year. Limited to 60 days for <a href="#">in-network providers</a> per calendar year for head/spinal injuries. <a href="#">Prior authorization</a> required. If you do not obtain <a href="#">Prior authorization</a> claims for those services will be denied and you will be responsible for payment of those services. Outpatient services: Limited to 30 visits for <a href="#">in-network providers</a> per calendar year. Limits do not apply to Mental Health and Substance Use Disorder Services.
	<a href="#">Skilled nursing care</a>	30% <a href="#">coinsurance</a>	Not covered	<a href="#">Prior authorization</a> required. If you do not obtain <a href="#">Prior authorization</a> claims for those services will be denied and you will be responsible for payment of those services. Limited to 60 days for <a href="#">in-network providers</a> per calendar year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<a href="#">Durable medical equipment</a>	Diabetic Supplies: No charge; <a href="#">deductible</a> does not apply All other equipment: 30% <a href="#">coinsurance</a>	Not covered	None
	<a href="#">Hospice services</a>	30% <a href="#">coinsurance</a>	Not covered	<a href="#">Prior authorization</a> required. If you do not obtain <a href="#">Prior authorization</a> claims for those services will be denied and you will be responsible for payment of those services. Respite care: Limited to 5 days, up to 30 days per lifetime for <a href="#">in-network providers</a> .
If your child needs dental or eye care	Children's eye exam	No charge; <a href="#">deductible</a> does not apply	Not covered	Limited to 1 exam per calendar year.
	Children's glasses	No charge; <a href="#">deductible</a> does not apply	Not covered	Limited to 1 pair per calendar year.
	Children's dental check-up	Not covered	Not covered	None

### 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](#).)

- Abortion
- Bariatric surgery
- Cosmetic surgery (with certain exceptions)
- Dental care (Adult)
- Dental care (Child)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (covered for diabetics)
- Weight loss programs

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

- Acupuncture (12 visits)
- Chiropractic care (20 visits)
- Hearing aids (one per ear every 3 calendar years)
- Non-emergency care when traveling outside the U.S. See [ProvidenceHealthPlan.com](#)

**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:

- Providence Health Plan at 503-574-8757/1-800-878-4445 (toll-free) or [ProvidenceHealthPlan.com](#).
- Oregon Division of Financial Regulation at 503-947-7984/1-888-877-4894 (toll-free) or [dfr.oregon.gov](#).

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 on how 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:

- Providence Health Plan at 503-574-8757/1-800-878-4445 (toll-free) or [ProvidenceHealthPlan.com](#).
- Oregon Division of Financial Regulation at 503-947-7984/1-888-877-4894 (toll-free) or [dfr.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 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' 1-800-878-4445 (TTY: 711).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-878-4445 (TTY: 711).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-878-4445 (TTY: 711).

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-878-4445 (TTY: 711).

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately one minute per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email [ebesa.opr@dol.gov](mailto:ebesa.opr@dol.gov) and reference the OMB Control Number 12100123.

## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$5,500
■ <a href="#">Specialist copayment</a>	\$80
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*pre-natal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
---------------------------	-----------------

In this example, Peg would pay:

<a href="#">Cost-Sharing</a>	
<a href="#">Deductibles</a>	\$5,500
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$2,100
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Peg would pay is</b>	<b>\$7,630</b>

### Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$5,500
■ <a href="#">Specialist copayment</a>	\$80
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
---------------------------	----------------

In this example, Joe would pay:

<a href="#">Cost-Sharing</a>	
<a href="#">Deductibles</a> *	\$100
<a href="#">Copayments</a>	\$1,100
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,200</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$5,500
■ <a href="#">Specialist copayment</a>	\$80
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
---------------------------	----------------

In this example, Mia would pay:

<a href="#">Cost-Sharing</a>	
<a href="#">Deductibles</a> *	\$2,100
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$400
<b>The total Mia would pay is</b>	<b>\$2,700</b>

\*Note: This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.



## Non-Discrimination Statement:

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex.

Providence Health Plan and Providence Health Assurance:

- 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, 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, you can call us at 503-574-7500 or 1-800-878-4445 (TTY: 711).

If you believe that Providence Health Plan and Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance  
Attn: Non-discrimination Coordinator  
PO Box 4158  
Portland, OR 97208-4158  
Email: [PHPAppealsandGrievances@providence.org](mailto:PHPAppealsandGrievances@providence.org)

If you need help filing a grievance, call us at 503-574-7500 or 1-800-878-4445 (TTY:711) for assistance.

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, DC 20201  
1-800-368-1019, 1-800-537-7697 (TTY)

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

Members of Oregon Plans may file a complaint with the Division of Financial Regulation at 1-888-877-4894 or visit <https://dfr.oregon.gov/Pages/index.aspx>.

**Language Access Services:**

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-878-4445 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-878-4445 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-878-4445 (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 1-800-878-4445 (TTY: 711)。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-878-4445 (телетайп: 711).

УВАГА: Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 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。1-800-878-4445 (TTY: 711) まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-878-4445 (رقم هاتف الصم والبكم: (TTY: 711).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-878-4445 (TTY: 711).

ប្រយ័ត្ន: បើសិនអ្នកនិយាយខ្មែរ, សេវាជំនួយផ្នែកភាសាសេរីគឺមានសំបាប់ឲ្យអ្នក។ ចូរទូរស័ព្ទ 1-800-878-4445 (TTY: 711)។

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-878-4445 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-878-4445 (TTY: 711).

فيم دشاب اب 1-800-878-4445 (TTY: 711) سامت دى رى گب. امش يارب ناگى ار تروصب ينابز تال ي هست، دى نك يم وگتفگ ي سراف نابز هب رگا: هجوت

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-878-4445 (ATS : 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-878-4445 (TTY: 711)