




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, [www.ProvidenceHealthPlan.com](http://www.ProvidenceHealthPlan.com). 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 [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-800-878-4445 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	<a href="#">In-Network</a> : \$250/per person \$750/per family (3 or more) <a href="#">Out-of-Network</a> : \$500/per person \$1,500/per family (3 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> .
<b>Are there services covered before you meet your deductible?</b>	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="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	Yes for prescriptions. \$50/person; \$150/family (3 or more). Does not apply to value drugs.	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
<b>What is the out-of-pocket limit for this plan?</b>	<a href="#">In-Network</a> : \$1,500/per person \$4,500/per family (3 or more) <a href="#">Out-of-Network</a> : \$4,000/per person \$12,000/per family (3 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.
<b>What is not included in the out-of-pocket limit?</b>	<a href="#">Premiums</a> , penalties, <a href="#">copays</a> or <a href="#">coinsurance</a> for Supplemental Benefits, 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> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.ProvidenceHealthPlan.com/providerdirectory">www.ProvidenceHealthPlan.com/providerdirectory</a> or call 1-800-878-4445.	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.
<b>Do you need a referral to see a specialist?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$10 <a href="#">copay</a> /visit	30% <a href="#">coinsurance</a>	<a href="#">Deductible</a> waived for the first four office visits <a href="#">in-network</a> per calendar year. Chronic condition visits for asthma, diabetes and heart conditions are covered in full <a href="#">in-network</a> .*
	<a href="#">Specialist</a> visit	\$10 <a href="#">copay</a> /visit	30% <a href="#">coinsurance</a>	Chronic condition visits for asthma, diabetes and heart conditions are covered in full <a href="#">in-network</a> .
	<a href="#">Preventive care/screening/immunization</a>	No charge. <a href="#">Deductible</a> does not apply.	30% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge. <a href="#">Deductible</a> does not apply.	30% <a href="#">coinsurance</a>	—————none—————
	Imaging (CT/PET scans, MRIs)	\$100 <a href="#">copay</a>	\$100 <a href="#">copay</a> then 30% <a href="#">coinsurance</a>	<a href="#">Copay</a> does not apply to cancer related services or <a href="#">out-of-pocket maximum</a> . <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.
<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="#">www.ProvidenceHealthPlan.com/pebb</a>	Value drug	No charge. <a href="#">Deductible</a> does not apply.	Not covered	Must be purchased at participating pharmacies. A \$1,000/person, \$3,000/family <a href="#">out-of-pocket maximum</a> applies.
	Generic drug	\$10 <a href="#">copay</a> retail \$25 <a href="#">copay</a> mail order	Not covered	Covers up to a 30-day supply (retail); 90-day supply (mail order).
	Brand-name drug	\$30 <a href="#">copay</a> retail \$75 <a href="#">copay</a> mail order	Not covered	<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.

\*For more information about limitations and exceptions, see the [plan](#) or policy document at [www.ProvidenceHealthPlan.com/pebb](#)

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="#">Specialty drug</a>	\$100 <a href="#">copay</a> retail	Not covered	If you request a brand-name drug when a generic is available, you pay the difference in cost, plus your <a href="#">copay</a> . <a href="#">Specialty drug</a> can only be purchased at a participating specialty pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$10 <a href="#">copay</a> /visit	\$100 <a href="#">copay</a> then 40% <a href="#">coinsurance</a>	<a href="#">Out-of-network copay</a> does not apply to the <a href="#">out-of-pocket maximum</a> . <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. Higher <a href="#">copay</a> and <a href="#">coinsurance</a> amounts apply to certain specialty services.*
	Physician/surgeon fees	\$10 <a href="#">copay</a> /visit	30% <a href="#">coinsurance</a>	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$150 <a href="#">copay</a>	\$150 <a href="#">copay</a>	For emergency medical conditions only. In-network <a href="#">deductible</a> applies both in and out-of-network. <a href="#">Copay</a> does not apply to <a href="#">out-of-pocket maximum</a> . If admitted to hospital all services subject to inpatient benefits.
	<a href="#">Emergency medical transportation</a>	\$75 <a href="#">copay</a> /trip	\$75 <a href="#">copay</a> /trip	<a href="#">In-network deductible</a> applies both in- and out-of-network.
	<a href="#">Urgent care</a>	\$25 <a href="#">copay</a> /visit	\$25 <a href="#">copay</a> /visit	<a href="#">In-network deductible</a> applies both in- and out-of-network.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$50/day \$250/admit	\$500 <a href="#">copay</a> then 40% <a href="#">coinsurance</a>	<a href="#">Out-of-network copay</a> does not apply to the <a href="#">out-of-pocket maximum</a> . <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. Higher <a href="#">copay</a> and <a href="#">coinsurance</a> amounts apply to certain specialty services*
	Physician/surgeon fees	No charge, <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	

\*For more information about limitations and exceptions, see the [plan](#) or policy document at [www.ProvidenceHealthPlan.com/pebb](http://www.ProvidenceHealthPlan.com/pebb)

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 mental health, behavioral health, or substance abuse services</b>	Outpatient services	Mental Health: \$10 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply Substance Abuse: No charge. <a href="#">Deductible</a> does not apply	30% <a href="#">coinsurance</a>	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. <a href="#">Out-of-network copay</a> does not apply to the <a href="#">out-of-pocket maximum</a> .
	Inpatient services	Mental Health: \$50/day; \$250/admit Substance Abuse: No charge. <a href="#">Deductible</a> does not apply	\$500 <a href="#">copay</a> then 30% <a href="#">coinsurance</a>	
<b>If you are pregnant</b>	Office visits	No charge. <a href="#">Deductible</a> does not apply	30% <a href="#">coinsurance</a>	—————none—————
	Childbirth/delivery professional services	No charge. <a href="#">Deductible</a> does not apply	30% <a href="#">coinsurance</a>	—————none—————
	Childbirth/delivery facility services	\$50/day \$250/admit	\$500 <a href="#">copay</a> then 40% <a href="#">coinsurance</a>	<a href="#">Out-of-network copay</a> does not apply to the <a href="#">out-of-pocket maximum</a> .
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	\$10 <a href="#">copay</a> / visit	30% <a href="#">coinsurance</a>	Limited to 180 visits per calendar year.
	<a href="#">Rehabilitation services</a>	Inpatient services: \$50/day; \$250/admit Outpatient services: \$10 <a href="#">copay</a> /visit	Inpatient services: \$500 <a href="#">copay</a> then 40% <a href="#">coinsurance</a> Outpatient services: 30% <a href="#">coinsurance</a>	Inpatient services: coverage limited to 30 days per calendar year 60 days for head and spinal cord injuries. Outpatient services: coverage limited to 60 visits per calendar year. Limits do not apply to Mental Health Services. <a href="#">Out-of-network copay</a> does not apply to the <a href="#">out-of-pocket maximum</a> .
	<a href="#">Habilitation services</a>	Inpatient services: \$50/day; \$250/admit Outpatient services: \$10 <a href="#">copay</a> /visit	Inpatient services: \$500 <a href="#">copay</a> then 40% <a href="#">coinsurance</a> Outpatient services: 30% <a href="#">coinsurance</a>	Inpatient services: coverage limited to 30 days per calendar year 60 days for head and spinal cord injuries. Outpatient services: coverage limited to 60 visits per calendar year. Limits do not apply to Mental Health Services. <a href="#">Out-of-network copay</a> does not apply to the <a href="#">out-of-pocket maximum</a> .

\*For more information about limitations and exceptions, see the [plan](#) or policy document at [www.ProvidenceHealthPlan.com/pebb](http://www.ProvidenceHealthPlan.com/pebb)

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="#">Skilled nursing care</a>	\$50/day \$250/admit	\$500 <a href="#">copay</a> then 30% <a href="#">coinsurance</a>	<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 180 days per calendar year. <a href="#">Out-of-network copay</a> does not apply to the <a href="#">out-of-pocket maximum</a> .
	<a href="#">Durable medical equipment</a>	15% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Diabetic supplies are covered in full. <a href="#">Prior authorization</a> required for some durable medical equipment. For more details see <a href="http://ProvidenceHealthPlan.com/PEBBPriorAuthorization">ProvidenceHealthPlan.com/PEBBPriorAuthorization</a> . If you do not obtain <a href="#">Prior Authorization claims</a> for those services will be denied and you will be responsible for payment of those services.
	<a href="#">Hospice services</a>	No charge. <a href="#">Deductible</a> does not apply	No charge. <a href="#">Deductible</a> does not apply	<a href="#">Prior authorization</a> required for out-of-network services. If you do not obtain <a href="#">Prior Authorization claims</a> for those services will be denied and you will be responsible for payment of those services.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	Coverage provided by separate carrier. See VSP plan.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	No coverage for dental check-up.

\*For more information about limitations and exceptions, see the [plan](#) or policy document at [www.ProvidenceHealthPlan.com/pebb](http://www.ProvidenceHealthPlan.com/pebb)

## 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 (with certain exceptions)
- Dental care (Adult)
- Dental check-up (Child)
- Eye exam and glasses (Child)
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (covered for diabetics)

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

- Acupuncture (Limited to 12 visits per calendar year)
- Bariatric surgery
- Chiropractic care (Limited to 20 visits per calendar year)
- Hearing aids (one per ear every 3 calendar years)
- Infertility treatment
- Non-emergency care when traveling outside the U.S. See [www.ProvidenceHealthPlan.com/pebb](http://www.ProvidenceHealthPlan.com/pebb)
- Weight loss programs

**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:

- PEBB COBRA Administrator at BenefitHelp Solutions (877) 433-6079 or (503) 765-3581
- For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).
- For non-federal governmental group health plans, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).
- Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact the Oregon Division of Financial Regulation at (888) 877-4894 or <https://dfr.oregon.gov/Pages/index.aspx> regarding their possible rights to continuation coverage under State law.

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 [www.HealthCare.gov](http://www.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 1-800-878-4445 or <http://www.ProvidenceHealthPlan.com/PEBB>
- PEBB Benefit Manager 503-373-1102
- Oregon Division of Financial Regulation at 503-947-7984/1-888-877-4894 (toll-free), or <https://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 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](#).

*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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$250
■ <a href="#">Specialist copayment</a>	\$10
■ Hospital (facility) <a href="#">copayment</a>	\$50
■ Other <a href="#">copayment</a>	\$50

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*)

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

In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$300
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$560</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>	\$250
■ <a href="#">Specialist copayment</a>	\$10
■ Hospital (facility) <a href="#">copayment</a>	\$50
■ Other <a href="#">copayment</a>	\$50

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:

Cost Sharing	
<a href="#">Deductibles</a>	\$300
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$620</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>	\$250
■ <a href="#">Specialist copayment</a>	\$10
■ Hospital (facility) <a href="#">copayment</a>	\$50
■ Other <a href="#">copayment</a>	\$50

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:

Cost Sharing	
<a href="#">Deductibles</a>	\$300
<a href="#">Copayments</a>	\$500
<a href="#">Coinsurance</a>	\$40
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$840</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



### 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, 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, or sex.

Providence Health Plan and Providence Health Assurance:

- Provide 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)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you are a Medicare member who needs these services, call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan or Providence Health Assurance 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 Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance  
Attn: Non-discrimination Coordinator  
PO Box 4158  
Portland, OR 97208-4158

If you need help filing a grievance, and you are a Medicare member call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. (TTY line at 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>.

## 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).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-878-4445 (TTY: 711) 번으로 전화해 주십시오

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: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 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).

با باشد می ف (TTY: 711) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما. بیگیرید تماس 1-800-878-4445

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)