



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, contact Moda Health at [www.modahealth.com](http://www.modahealth.com) or by calling 1-888-445-7413. 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.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-888-445-7413 to request a copy.

| Important Questions   | Answers  | Why This Matters:   |
|---|--|---|
| What is the overall <a href="#">deductible</a> ?                                | \$1,000 individual / \$2,500 family.   | 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. Examples of some services: In-network hospice care and diabetes self-management program as well as in and out-of-network prescription medications, spinal manipulation, naturopathic supplies, massage therapy, vision care and most <a href="#">preventive care</a> are covered before you meet your <a href="#">deductible</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> .   |
| Are there other <a href="#">deductibles</a> for specific services?              | Yes, \$300 for prescription medications in a calendar year   | 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.  |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$6,150 individual / \$12,300 family for medical services and prescription medications, in-network and out-of-network combined.  | 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="#">coinsurance</a> for hearing aids for age 26 and older, <a href="#">coinsurance</a> for brand medications when generic medications are available, penalties for failure to obtain prior authorization, <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover. | 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://www.modahealth.com">www.modahealth.com</a> or call 1-888-445-7413 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. |

| Important Questions  | Answers | Why This Matters:  |
|--|---------|--|
| 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> . |



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<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most)  |  |
| If you visit a health care <a href="#">provider's</a> office or clinic | Primary care visit to treat an injury or illness                           | 30% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>   | None   |
|  | <a href="#">Specialist</a> visit   | 30% <a href="#">coinsurance</a><br><br>50% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply to spinal manipulation, naturopathic supplies and massage therapy | 50% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply to spinal manipulation, naturopathic supplies and massage therapy | Office visits by chiropractors, naturopathic physicians and acupuncturists do not have a dollar or visit limit. \$300 plan year maximum for spinal manipulation, naturopathic supplies and massage therapy. 20 visits plan year maximum for acupuncture care. \$300 limit does not apply to the insertion of needles for acupuncture care. |
|  | <a href="#">Preventive care</a> / <a href="#">screening</a> / immunization | No charge for most services.<br><br>30% <a href="#">coinsurance</a> for remaining services and <a href="#">deductible</a> does not apply.  | 50% <a href="#">coinsurance</a> and <a href="#">deductible</a> does not apply to most services.   | Includes preventive tests. You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.   |
| If you have a test   | <a href="#">Diagnostic test</a> (x-ray, blood work)                        | 30% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>   | Includes other tests such as EKG, allergy testing and sleep study.   |
|  | Imaging (CT/PET scans, MRIs)   | 30% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>   | <a href="#">Prior authorization</a> is required for many services. Failure to obtain <a href="#">prior authorization</a> results in denial. In-network providers are responsible to obtain <a href="#">prior authorization</a> and will write off the charges due to no <a href="#">prior authorization</a> .                              |

| Common Medical Event  | Services You May Need                            | What You Will Pay   |   | Limitations, Exceptions, & Other Important Information   |
|---|--|---|---|--|
|   |  | Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most)                              |  |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.welldynrx.com">www.welldynrx.com</a> | Value Prescription                               | 30% <a href="#">coinsurance</a> up to \$4 maximum <a href="#">copay</a> /retail,<br><br>30% <a href="#">coinsurance</a> up to \$8 maximum <a href="#">copay</a> /mail-order | 30% <a href="#">coinsurance</a> up to \$4 maximum <a href="#">copay</a> /retail | Prescription drug benefits are administered by WellDyneRx. <a href="#">Prior authorization</a> may be required.<br><br><u>Retail</u> - Up to a 30-day supply.<br><br><u>Mail order</u> - 90-day supply. Mail-order prescriptions required to be filled in-network.<br><br>Prescriptions purchased at an out-of-network pharmacy may be subject to "balance billing." You are responsible to pay the difference in cost between brand and generic drug when generic is available. |
|   | Retail Prescription                              | 30% <a href="#">coinsurance</a>   | 30% <a href="#">coinsurance</a>   |  |
|   | Mail Order Prescription                          | 30% <a href="#">coinsurance</a>   | Not covered   |  |
|   | Specialty Medications                            | 30% <a href="#">coinsurance</a>   | Not covered   | <u>Specialty</u> – Up to a 30-day supply. Exclusive pharmacy only.   |
| <b>If you have outpatient surgery</b>   | Facility fee (e.g., ambulatory surgery center)   | 30% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>   | <a href="#">Prior authorization</a> may be required. Failure to obtain <a href="#">prior authorization</a> results in a penalty and the procedure is not covered if not medically necessary. In-network sterilization procedures are covered with no cost sharing.   |
|   | Physician/surgeon fees                           | 30% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>   |  |
| <b>If you need immediate medical attention</b>  | <a href="#">Emergency room care</a>              | \$100 <a href="#">copay</a> /visit, then 30% <a href="#">coinsurance</a>  | \$100 <a href="#">copay</a> /visit, then 30% <a href="#">coinsurance</a>        | <a href="#">Copay</a> waived if hospital admission immediately follows.  |
|   | <a href="#">Emergency medical transportation</a> | 30% <a href="#">coinsurance</a>   | 30% <a href="#">coinsurance</a>   | Transport to nearest facility capable to provide necessary treatment.  |
|   | <a href="#">Urgent care</a>                      | 30% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>   | None.  |
| <b>If you have a hospital stay</b>  | Facility fee (e.g., hospital room)               | 30% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>   | <a href="#">Prior authorization</a> is required. Failure to obtain <a href="#">prior authorization</a> results in a penalty and the procedure is not covered if not medically necessary.   |
|   | Physician/surgeon fees                           | 30% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>   |  |

| Common Medical Event  | Services You May Need                     | What You Will Pay                            |  | Limitations, Exceptions, & Other Important Information  |
|---|---|--|--|---|
|   |   | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |   |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | 30% <a href="#">coinsurance</a>              | 50% <a href="#">coinsurance</a>                    | <a href="#">Prior authorization</a> required for all inpatient and some outpatient behavioral health services. Failure to obtain <a href="#">prior authorization</a> results in a penalty and the procedure is not covered if not medically necessary.  |
|   | Inpatient services                        | 30% <a href="#">coinsurance</a>              | 50% <a href="#">coinsurance</a>                    |   |
| If you are pregnant   | Office visits                             | 30% <a href="#">coinsurance</a>              | 50% <a href="#">coinsurance</a>                    | <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copay</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).  |
|   | Childbirth/delivery professional services | 30% <a href="#">coinsurance</a>              | 50% <a href="#">coinsurance</a>                    |   |
|   | Childbirth/delivery facility services     | 30% <a href="#">coinsurance</a>              | 50% <a href="#">coinsurance</a>                    |   |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>          | 30% <a href="#">coinsurance</a>              | 50% <a href="#">coinsurance</a>                    | Plan year maximum of 60 visits. <a href="#">Prior authorization</a> is required. Failure to obtain <a href="#">prior authorization</a> results in a penalty and the procedure is not covered if not medically necessary.  |
|   | <a href="#">Rehabilitation services</a>   | 30% <a href="#">coinsurance</a>              | 50% <a href="#">coinsurance</a>                    | Plan year maximum of 60 sessions for outpatient rehabilitation. Habilitation services are limited to services that qualify under rehabilitation guidelines and medically necessary to treat a mental health condition. <a href="#">Prior authorization</a> is required. Failure to obtain <a href="#">prior authorization</a> results in a penalty and the procedure is not covered if not medically necessary. |
|   | <a href="#">Habilitation services</a>     | 30% <a href="#">coinsurance</a>              | 50% <a href="#">coinsurance</a>                    |   |
|   | <a href="#">Skilled nursing care</a>      | 30% <a href="#">coinsurance</a>              | 50% <a href="#">coinsurance</a>                    | Plan year maximum of 100 visits. <a href="#">Prior authorization</a> is required. Failure to obtain <a href="#">prior authorization</a> results in a penalty and the procedure is not covered if not medically necessary.   |
|   | <a href="#">Durable medical equipment</a> | 30% <a href="#">coinsurance</a>              | 50% <a href="#">coinsurance</a>                    | Includes supplies and prosthetics. <a href="#">Prior authorization</a> may be required. Failure to obtain <a href="#">prior authorization</a> results in a penalty and the procedure is not covered if not medically necessary.   |
|   | <a href="#">Hospice services</a>          | No charge                                    | 50% <a href="#">coinsurance</a>                    | Plan year maximum of 120 hours for respite care in a 3 month period.  |

| Common Medical Event                   | Services You May Need      | What You Will Pay                            |  | Limitations, Exceptions, & Other Important Information  |
|--|----------------------------|--|--|---|
|  |                            | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |   |
| If your child needs dental or eye care | Children's eye exam        | No charge                                    | No charge  | Preventive eye exam limited to in-network for children age 3-5. Eye exams are not covered for other ages. |
|  | Children's glasses         | Not covered                                  | Not covered  | None.   |
|  | Children's dental check-up | Not covered                                  | Not covered  | None  |

### Excluded Services & Other Covered Services:

| Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)           |   |  |  |
|---|---|--|--|
| <ul style="list-style-type: none"> <li>Bariatric surgery</li> <li>Cosmetic surgery, except as required for certain situations</li> <li>Dental care (Adult), except for accident related injuries</li> </ul> | <ul style="list-style-type: none"> <li>Infertility treatment</li> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>Private-duty nursing</li> <li>Routine eye care (Adult)</li> <li>Routine foot care, except for diabetes</li> <li>Weight loss programs</li> </ul> |  |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)  |   |  |  |
| <ul style="list-style-type: none"> <li>Abortion</li> <li>Acupuncture</li> </ul>   | <ul style="list-style-type: none"> <li>Chiropractic care</li> </ul>   | <ul style="list-style-type: none"> <li>Hearing aids</li> </ul>   |  |

**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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or <http://www.dol.gov/ebsa/healthreform> for group health coverage subject to ERISA, the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov) for non-federal governmental group health plans, and the Oregon Division of Financial Regulation at 1-888-877-4894 or [www.dfr.oregon.gov](http://www.dfr.oregon.gov) for Church plans. 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 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: Moda Health at 1-888-217-2363. For group health coverage subject to ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your [appeal](#). Contact the Oregon Division of Financial Regulation at 1-888-877-4894 or [www.dfr.oregon.gov](http://www.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](#).

#### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 888-786-7461.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 888-873-1395.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 888-873-1395.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 888-873-1395.

*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](#) \$1,000
- [Specialist coinsurance](#) 30%
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

This EXAMPLE event includes services like:

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

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

In this example, Peg would pay:

| Cost Sharing                |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$1,000 |
| <a href="#">Copayments</a>  | \$0     |
| <a href="#">Coinsurance</a> | \$3,400 |

| What isn't covered         |         |
|----------------------------|---------|
| Limits or exclusions       | \$50    |
| The total Peg would pay is | \$4,450 |

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist coinsurance](#) 30%
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

This EXAMPLE event includes services like:

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

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

In this example, Joe would pay:

| Cost Sharing                |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$1,000 |
| <a href="#">Copayments</a>  | \$0     |
| <a href="#">Coinsurance</a> | \$1,900 |

| What isn't covered         |         |
|----------------------------|---------|
| Limits or exclusions       | \$20    |
| The total Joe would pay is | \$2,920 |

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist coinsurance](#) 30%
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

This EXAMPLE event includes services like:

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

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

In this example, Mia would pay:

| Cost Sharing                |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$1,000 |
| <a href="#">Copayments</a>  | \$0     |
| <a href="#">Coinsurance</a> | \$300   |

| What isn't covered         |         |
|----------------------------|---------|
| Limits or exclusions       | \$0     |
| The total Mia would pay is | \$1,300 |

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



# Nondiscrimination notice

**We follow federal civil rights laws. We do not discriminate based on race, color, national origin, age, disability, gender identity, sex or sexual orientation.**

We provide free services to people with disabilities so that they can communicate with us. These include sign language interpreters and other forms of communication.

If your first language is not English, we will give you free interpretation services and/or materials in other languages.

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**If you need any of the above,  
call Customer Service at:**

888-217-2363 (TDD/TTY 711)

**If you think we did not offer these  
services or discriminated, you  
can file a written complaint.**

**Please mail or fax it to:**

Moda Partners, Inc.  
Attention: Appeal Unit  
601 SW Second Ave.  
Portland, OR 97204  
Fax: 503-412-4003

**If you need help filing a complaint,  
please call Customer Service.**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights at [ocrportal.hhs.gov/ocr/portal/lobby.jsf](https://ocrportal.hhs.gov/ocr/portal/lobby.jsf), or by mail or phone:

U.S. Department of Health  
and Human Services  
200 Independence Ave. SW, Room 509F  
HHH Building, Washington, DC 20201  
800-368-1019, 800-537-7697 (TDD)

You can get Office for Civil Rights complaint forms at [hhs.gov/ocr/office/file/index.html](https://hhs.gov/ocr/office/file/index.html).

**Dave Nesseler-Cass coordinates  
our nondiscrimination work:**

Dave Nesseler-Cass,  
Chief Compliance Officer  
601 SW Second Ave.  
Portland, OR 97204  
855-232-9111  
[compliance@modahealth.com](mailto:compliance@modahealth.com)



ATENCIÓN: Si habla español, hay disponibles servicios de ayuda con el idioma sin costo alguno para usted. Llame al 1-877-605-3229 (TTY: 711).

CHÚ Ý: Nếu bạn nói tiếng Việt, có dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Gọi 1-877-605-3229 (TTY:711)

注意：如果您說中文，可得到免費語言幫助服務。請致電1-877-605-3229（聾啞人專用：711）

주의: 한국어로 무료 언어 지원 서비스를 이용하시려면 다음 연락처로 연락해주시기 바랍니다. 전화 1-877-605-3229 (TTY: 711)

PAUNAWA: Kung nagsasalita ka ng Tagalog, ang mga serbisyong tulong sa wika, ay walang bayad, at magagamit mo. Tumawag sa numerong 1-877-605-3229 (TTY: 711)

تنبيه: إذا كنت تتحدث العربية، فهناك خدمات مساعدة لغوية متاحة لك مجانًا. اتصل برقم (الهاتف النصي: 711) 1-877-605-3229

بولتے ہیں تو لانی (URDU) توجہ دیں: اگر آپ اردو اعانت آپ کے لیے بلا معاوضہ دستیاب ہے۔ 1-877-605-3229 (TTY: 711) پر کال کریں

ВНИМАНИЕ! Если Вы говорите по-русски, воспользуйтесь бесплатной языковой поддержкой. Позвоните по тел. 1-877-605-3229 (текстовый телефон: 711).

ATTENTION : si vous êtes locuteurs francophones, le service d'assistance linguistique gratuit est disponible. Appelez au 1-877-605-3229 (TTY : 711)

توجہ: در صورتی کہ بہ فارسی صحبت می کنید، خدمات ترجمہ بہ صورت رایگان برای شما موجود است. با (TTY: 711) 1-877-605-3229 تماس بگیرید.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपको भाषाई सहायता बिना कोई पैसा दिए उपलब्ध है। 1-877-605-3229 पर कॉल करें (TTY: 711)

Achtung: Falls Sie Deutsch sprechen, stehen Ihnen kostenlos Sprachassistentendienste zur Verfügung. Rufen sie 1-877-605-3229 (TTY: 711)

注意：日本語をご希望の方には、日本語サービスを無料で提供しております。1-877-605-3229（TTY、テレタイプライターをご利用の方は711）までお電話ください。

အကူအညီ: နှစ် ဘာသာစုံ (မြန်မာစကားပြော မြန်မာ အင်္ဂလိပ် စကားပြော) ဝတ်လဲ ဖွဲ့စည်း မြန်မာစကားပြော မြန်မာ မူရင်း နှစ် ဘာသာစုံ ဖွဲ့စည်း 1-877-605-3229 (TTY: 711) နှစ် ဘာသာစုံ

ໂປດຊາວ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການຊ່ວຍເຫຼືອດ້ານພາສາແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ເສັຍຄ່າ. ໂທ 1-877-605-3229 (TTY: 711)

УВАГА! Якщо ви говорите українською, для вас доступні безкоштовні консультації рідною мовою. Зателефонуйте 1-877-605-3229 (TTY: 711)

ATENȚIE: Dacă vorbiți limba română, vă punem la dispoziție serviciul de asistență lingvistică în mod gratuit. Sunați la 1-877-605-3229 (TTY 711)

THOV CEEB TOOM: Yog hais tias koj hais lus Hmoob, muaj cov kev pab cuam txhais lus, pub dawb rau koj. Hu rau 1-877-605-3229 (TTY: 711)

ត្រូវចងចាំ៖ បើអ្នកនិយាយភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដោយឥតគិតថ្លៃ គឺមានផ្តល់ជូនលោកអ្នក។ សូមទូរស័ព្ទទៅកាន់លេខ 1-877-605-3229 (TTY: 711)

HUBACHIIISA: Yoo afaan Kshtik kan dubbattan ta'e tajaajiloonni gargaarsaa isiniif jira 1-877-605-3229 (TTY:711) tiin bilbilaa.

โปรดทราบ: หากคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี โทร 1-877-605-3229 (TTY: 711)

FA'AUTAGIA: Afai e te tautala i le gagana Samoa, o loo avanoa fesoasoani tau gagana mo oe e le totogia. Vala'au i le 1-877-605-3229 (TTY: 711)

IPANGAG: Nu agsasaoka iti Ilocano, sidadaan ti tulong iti lengguahe para kenka nga awan bayadna. Umawag iti 1-877-605-3229 (TTY: 711)

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń: 1-877-605-3229 (obsługa TTY: 711)