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 contribution) 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 or call 1 (866) 240-9580. For general definitions of common terms, such as allowed amount, balance billing, cost-share, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at healthcare.gov/sbc-glossary or call 1 (866) 240-9580 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Preferred and participating: $1,500 individual / $3,000 family per calendar year. Nonparticipating: $3,000 individual / $6,000 family per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Certain preventive care and those services listed below as "deductible does not apply" or as "No charge."	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or cost-share may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $200 per individual for prescription drug coverage. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Preferred and participating: $3,000 individual / $6,000 family per calendar year. Nonparticipating: $5,000 individual / $10,000 family per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See https://regence.com/go/ID/Preferred or call 1 (866) 240-9580 for a list of network providers.	You pay the least if you use a provider in the preferred network. You pay more if you use a provider in the participating network. You will pay the most if you use a nonparticipating provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use a nonparticipating provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **cost-share** 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
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Nonparticipating Provider (You pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay / office visit, deductible does not apply; $30 copay / retail clinic visit, deductible does not apply; 20% cost-share, deductible does not apply for expanded office and outpatient hospital services; 20% cost-share for all other services	$30 copay / office visit, deductible does not apply; $30 copay / retail clinic visit, deductible does not apply; 50% cost-share, deductible does not apply for expanded office and outpatient hospital services; 50% cost-share for all other services	50% cost-share	Copayment applies to each preferred or participating office and retail clinic visit only. Expanded office and outpatient hospital services include, but are not limited to, medical/surgical services and therapeutic injections performed by a physician. All other services are covered at the cost-share specified, after deductible.
	Specialist visit	$50 copay / office visit, deductible does not apply; 20% cost-share, deductible does not apply for expanded office and outpatient hospital services; 20% cost-share for all other services	$50 copay / office visit, deductible does not apply; 20% cost-share, deductible does not apply for expanded office and outpatient hospital services; 50% cost-share for all other services	50% cost-share	
	Preventive care/screening/ immunization	No charge	No charge	No charge	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.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Nonparticipating Provider (You pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	20% cost-share, deductible does not apply for outpatient services 20% cost-share for inpatient services	50% cost-share	50% cost-share	None
	Imaging (CT/PET scans, MRIs)	20% cost-share, deductible does not apply for outpatient services 20% cost-share for inpatient services	50% cost-share	50% cost-share	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://regence.com/go/2021/ID/4tier	Generic drugs	$10 copay / retail prescription $10 copay / mail order prescription			Deductible does not apply for generic drugs. 90-day supply / generic drug retail or mail order prescription 90-day supply / mail order prescription 34-day supply / self-injectable medications, preferred brand drugs or brand drugs retail prescription 30-day supply / specialty drug retail prescription Specialty drugs are not available through mail order. Coverage includes compound medications, refer to your plan for further information. No charge for certain preventive drugs, women's contraceptives and immunizations at a participating pharmacy. You are responsible for the difference in cost between a dispensed brand drug and the equivalent generic drug, in addition to the
	Preferred brand drugs	25% cost-share ($25 minimum, up to $100 maximum) / retail prescription 25% cost-share ($25 minimum, up to $100 maximum) / mail order prescription			
	Brand drugs	50% cost-share ($75 minimum, up to $200 maximum) / retail prescription 50% cost-share ($75 minimum, up to $200 maximum) / mail order prescription			

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Nonparticipating Provider (You pay the most)	
	Specialty drugs	50% cost-share up to $300 maximum / retail prescription			copayment and/or cost-share. The first fill of specialty drugs 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.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% cost-share	50% cost-share	50% cost-share	None
	Physician/surgeon fees	20% cost-share	50% cost-share	50% cost-share	None
If you need immediate medical attention	Emergency room care	20% cost-share after $150 copay / visit	20% cost-share after $150 copay / visit	20% cost-share after $150 copay / visit	Copayment applies to facility charge for each visit (waived if admitted), whether or not the deductible has been met. Preferred and participating deductible applies to preferred, participating and nonparticipating services.
	Emergency medical transportation	20% cost-share	20% cost-share	20% cost-share	Preferred and participating deductible applies to preferred, participating and nonparticipating services.
	Urgent care	Covered the same as **If you visit a health care provider's office or clinic** (Primary care visit or Specialist visit) or **If you have a test** above.			None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% cost-share	50% cost-share	50% cost-share	None
	Physician/surgeon fees	20% cost-share	50% cost-share	50% cost-share	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Nonparticipating Provider (You pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay / office visit, deductible does not apply; No charge for all other services	$30 copay / office visit, deductible does not apply; No charge for all other services	50% cost-share	Copayment applies to each preferred or participating office/psychotherapy visit only. All other services are covered at the cost-share specified, after deductible
	Inpatient services	20% cost-share	20% cost-share	50% cost-share	None
If you are pregnant	Office visits	20% cost-share, deductible does not apply for physician services	50% cost-share	50% cost-share	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, cost-share or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% cost-share, deductible does not apply for physician services	50% cost-share	50% cost-share	
	Childbirth/delivery facility services	20% cost-share	50% cost-share	50% cost-share	
If you need help recovering or have other special health needs	Home health care	20% cost-share	50% cost-share	50% cost-share	130 visits / year
	Rehabilitation services	20% cost-share	50% cost-share	50% cost-share	22 inpatient days / year 30 outpatient visits / year Includes physical therapy, occupational therapy and speech therapy.
	Habilitation services	20% cost-share	50% cost-share	50% cost-share	28 outpatient neurodevelopmental visits / year Neurodevelopmental therapy limited to individuals under age 7. Includes physical therapy, occupational therapy and speech therapy.
	Skilled nursing care	20% cost-share	50% cost-share	50% cost-share	60 inpatient days / year
	Durable medical equipment	20% cost-share	50% cost-share	50% cost-share	None
	Hospice services	20% cost-share	50% cost-share	50% cost-share	14 respite inpatient or outpatient days / lifetime

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Nonparticipating Provider (You pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	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, except when performed to preserve the life of the enrolled female individual
- Bariatric surgery
- Cosmetic surgery, except congenital anomalies
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care, except for diabetic patients
- Weight loss programs

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

- Acupuncture
- Chiropractic care, spinal manipulations only
- Hearing aids
- 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 cciio.cms.gov or your state insurance department. You may also contact the plan at 1 (866) 240-9580. 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 (866) 240-9580 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 Idaho Department of Insurance by calling 1 (208) 334-4250 or the toll-free message line at 1 (800) 721-3272; by writing to the Idaho Department of Insurance, Consumer Affairs, 700 W State Street, 3rd Floor; P.O. Box 83720, Boise, ID 83720-0043; through the Internet at: doi/Idaho.gov; or by E-mail at: consumeraffairs@doi.idaho.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 1 (866) 240-9580.

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 cost-share) 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	**$1,500**
Specialist copayment	**$50**
Hospital (facility) cost-share	**20%**
Other cost-share	**20%**

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	
Deductibles	$1,500
Copayments	$0
Cost-Share	$1,500
What isn't covered	
Limits or exclusions	$61
The total Peg would pay is	**$3,061**

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

The plan's overall deductible	**$1,500**
Specialist copayment	**$50**
Hospital (facility) cost-share	**20%**
Other cost-share	**20%**

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	
Deductibles	$990
Copayments	$354
Cost-Share	$748
What isn't covered	
Limits or exclusions	$178
The total Joe would pay is	**$2,270**

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

The plan's overall deductible	**$1,500**
Specialist copayment	**$50**
Hospital (facility) cost-share	**20%**
Other cost-share	**20%**

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	
Deductibles	$1,500
Copayments	$305
Cost-Share	$161
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,966**

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

The Summary of Benefits and Coverage (SBC) document will help you choose a vision plan. The SBC shows you how you and the plan would share the cost for covered vision care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to regence.com. For provider or benefit questions call VSP at 1 (844) 299-3041. For membership questions call Regence at 1 (866) 240-9580. 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 (866) 240-9580 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Vision Event chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not applicable.	See the Common Vision Event chart below for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	See the Common Vision Event chart below for your costs for services this plan covers.
What is the out-of-pocket limit for this plan?	Not applicable.	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not applicable.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. See https://regence.com/go/VSPNetwork or call 1 (844) 299-3041 for a list of VSP doctors.	This plan uses a vision provider network (Vision Service Plan). You will pay less if you use a vision provider in the plan's network. You will pay the most if you use an out-of-network vision provider, and you might receive a bill from a vision provider for the difference between the provider's charge and what your plan pays (balance billing).
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

Common Vision Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		VSP Doctor (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a vision care provider's office or clinic	Routine vision examination and vision hardware	No charge up to the VSP doctor limit	No charge up to the out-of-network provider limit	For services provided by an out-of-network provider, you pay all charges up front then submit a claim for reimbursement. 1 routine eye examination / calendar year Routine eye examination limited to $45 for out-of-network providers. 1 pair of frames / calendar year Frames limited to $350 for VSP doctors. Frames limited to $190 for VSP approved wholesale/retail vendors. Frames limited to $70 for out-of-network providers. 1 pair of standard glass or plastic lenses / calendar year for either: Single vision lenses; Lined bifocal (or standard progressive) lenses; Lined trifocal lenses; Lenticular lenses; or Contact lenses*. Elective contact lenses* limited up to $150 for VSP doctors. Necessary contact lenses* limited to a calendar year supply for VSP doctors. Single vision lenses limited to $30 for out-of-network providers. Lined bifocal (or standard progressive) lenses limited to $50 for out-of-network providers. Lined trifocal lenses limited to $65 for out-of-network providers. Lenticular lenses limited to $100 for out-of-network providers.

Common Vision Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		VSP Doctor (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				Elective contact lenses* (including fitting/evaluation services) limited to $105 once / calendar year for out-of-network providers. Necessary contact lenses* (including fitting/evaluation services) limited to a calendar year supply up to $210 for out-of-network providers. *Contact lenses are in lieu of all other frame and lens benefits. When you receive contact lenses, you will not be eligible for any frames or other types of lenses until the next calendar year.
	Contact lens evaluation and fitting examination	$60 copay	No charge up to the out-of-network provider limit	For services provided by an out-of-network provider, you pay all charges up front then submit a claim for reimbursement. 1 contact lens evaluation and fitting examination / calendar year Elective contact lens evaluation and fitting examination (including elective contacts lenses) limited to $105 for out-of-network providers. Necessary contact lens evaluation and fitting examination (including necessary contacts lenses) limited to $210 for out-of-network providers.
	Low vision supplemental examinations (testing)	No charge	No charge up to the out-of-network provider limit	For services provided by an out-of-network provider, you pay all charges up front then submit a claim for reimbursement. $1,000 low vision maximum / 2 calendar years, including supplemental examinations (testing) and care aids 2 supplemental examinations / 2 calendar years Supplemental examinations limited to $125 for out-of-network providers.
	Low vision supplemental care aids	25% coinsurance	25% coinsurance	

Excluded Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Corrective vision treatment of an experimental nature • Cosmetic services and supplies	• Fees, taxes and interest • Medical or surgical treatment of the eyes • Non-direct patient care	• Orthoptics or vision training • Plano lenses • Two pair of glasses in lieu of bifocals

NONDISCRIMINATION NOTICE

Regence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Regence does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Regence:
Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, and accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services listed above, please contact:

Medicare Customer Service
1-800-541-8981 (TTY: 711)

Customer Service for all other plans
1-888-344-6347 (TTY: 711)

If you believe that Regence has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our civil rights coordinator below.

For VSP vision services, contact: **VSP**
1-844-299-3041 (TTY: 1-800-428-4833)

VSP provides administration for your Regence vision plan. 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.

Medicare Customer Service
Civil Rights Coordinator
MS: B32AG, PO Box 1827
Medford, OR 97501
1-866-749-0355, (TTY: 711)
Fax: 1-888-309-8784
medicareappeals@regence.com

Customer Service for all other plans
Civil Rights Coordinator
MS CS B32B, P.O. Box 1271
Portland, OR 97207-1271
1-888-344-6347, (TTY: 711)
CS@regence.com

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

U.S. Department of Health and Human Services
200 Independence Avenue SW,
Room 509F HHH Building
Washington, DC 20201

1-800-368-1019, 800-537-7697 (TDD).

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

Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-344-6347 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-344-6347 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-344-6347 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-344-6347 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-344-6347 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-344-6347 (телетайп: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-344-6347 (ATS : 711)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-344-6347（TTY:711）まで、お電話にてご連絡ください。

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-888-344-6347 (TTY: 711.)

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea te ke lava 'o ma'u ia. ha'o telefonimai mai ki he fika 1-888-344-6347 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-344-6347 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-344-6347 (TTY: 711)។

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

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

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

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