Your Benefit Summary
Total Enhanced 7000 Gold

Providence Health Plan

Providence Signature Network	In-Network	Out-of-Network
Individual Calendar Year Deductible (family amount is 2 times individual)	$7,000 Common	
Individual Out-of-Pocket Maximum (family amount is 2 times individual) This amount includes the Deductible.	$7,500 Common	

Important information about your plan

This summary provides only highlights of your benefits. To view your plan details, register and login at myProvidence.com.

- In-Network and Out-of-Network Services accumulate toward your common Deductible and common Out-of-Pocket Maximum.
- Some Services and penalties do not apply to the Out-of-Pocket Maximum.
- Prior Authorization is required for some Services.
- View a list of In-Network Providers and pharmacies at ProvidenceHealthPlan.com/findaprovider.
- To get the most out of your benefits, use the providers within the Providence Signature network.
- If you choose to go outside the network, you may be subject to billing for charges that are above Usual, Customary and Reasonable charges (UCR). Benefits for Out-of-Network services are based on these UCR charges.
- Limitations and exclusions apply. See your handbook for details.
- Medicare Part D creditable.
- Find important information about how to use your plan at ProvidenceHealthPlan.com/usingyourplan.
- Learn more about PHP's covered preventive services rated “A” or “B” by the U.S. Preventive Services Task Force at ProvidenceHealthPlan.com/PreventiveCare.

✓ **Deductible does not apply**	Below is the amount you pay after you have met your calendar year Deductible In-Network	Out-of-Network
On-Demand Visits		
Providence ExpressCare Virtual	Covered in full ✓	Not covered
Providence ExpressCare Retail Health Clinic visits	Covered in full ✓	Not applicable
Preventive Care		
Periodic health exams and well-baby care	Covered in full ✓	40% ✓
Routine immunizations and shots	Covered in full ✓	40% ✓
Colonoscopy (preventive, age 45+)	Covered in full ✓	40%
Gynecological exams (1 per calendar year), breast exams and Pap tests	Covered in full ✓	40%
Mammograms	Covered in full ✓	40%
Nutritional Counseling	Covered in full ✓	40%
Tobacco cessation, counseling/classes and deterrent medications	Covered in full ✓	Not covered
Physician/Professional Services		
Office visits to a Primary Care Provider		40% ✓
In-Person	$20 ✓	
Virtually	$10 ✓	
Office visits to an Alternative Care Provider (In-Person or Virtually) (such as naturopath) (Chiropractic manipulation and acupuncture services are covered separately from the office visit at the levels listed for those benefits.)	$20 ✓	40% ✓
Office visits to specialists (In-Person or Virtually)	$40 ✓	40% ✓
Inpatient Hospital visits	30%	40%
Allergy shots and allergy serums, injectable and infused medications	30%	40%
Surgery and anesthesia in an office or facility	30%	40%
Diagnostic Services		
X-ray, lab and testing services (includes ultrasound)	30% ✓	40%
High-tech imaging Services (such as PET, CT or MRI)	30%	40%

Your Benefit Summary

✓ Deductible does not apply	Below is the amount you pay after you have met your calendar year Deductible In-Network	Out-of-Network
Diagnostic Services		
Sleep studies	30% ✓	40%
Emergency Care and Urgent Care Services		
Emergency Services (For Emergency Medical Conditions only. If admitted to the Hospital, all Services subject to inpatient benefits.)	$250 then 30% ✓	$250 then 30% ✓
Emergency medical transportation (air and/or ground) (Emergency transportation is covered under your In-Network benefit, regardless of whether or not the provider is an In-Network Provider.)	30%	30%
Urgent Care visits (for non-life threatening illness/minor injury)	$40 ✓	40% ✓
Hospital Services		
Inpatient/Observation care	30%	40%
Skilled Nursing Facility (limited to 60 days per calendar year)	30%	40%
Inpatient rehabilitative care (Limited to 30 days per calendar year; 60 days for head/spinal injuries. Limits do not apply to Mental Health Services.)	30%	40%
Inpatient habilitative care (Limited to 30 days per calendar year; 60 days for head/spinal injuries. Limits do not apply to Mental Health Services.)	30%	40%
Outpatient Services		
Outpatient surgery at an Ambulatory Surgery Center	20%	40%
Outpatient surgery at a Hospital-based facility	30%	40%
Colonoscopy (non-preventive) at an Ambulatory Surgery Center	20%	40%
Colonoscopy (non-preventive) at a Hospital-based facility	30%	40%
Outpatient dialysis, infusion, chemotherapy and radiation therapy	30%	40%
Cardiac Rehabilitation (post-surgery)	First 16 visits Covered in full ✓ then 30% after deductible	40%
Outpatient rehabilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year; up to 30 additional visits per specified condition. Limits do not apply to Mental Health Services.)		
Physical Therapy	30% ✓	40%
Occupational or Speech Therapy	30% ✓	40%
Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year; up to 30 additional visits per specified condition. Limits do not apply to Mental Health Services.)	30% ✓	40%
Vision Therapy (convergence insufficiency) (Limited to 12 visits per lifetime)	30%	40%
Maternity Services		
Prenatal visits	Covered in full ✓	40%
Delivery and postnatal physician/provider visits	30%	40%
Inpatient Hospital/facility services	30%	40%
Routine newborn nursery care	30%	40%
Medical Equipment, Supplies and Devices		
Medical equipment, appliances, prosthetics/orthotics and supplies	30%	40%
Diabetes supplies (such as lancets, test strips, needles and glucose monitors)	30% ✓	40%
Hearing aids (Limited to one aid per ear every 3 calendar years)	30%	40%
Removable custom shoe orthotics (Limited to $200 per calendar year)	30% ✓	40% ✓
Mental Health and Substance Use Disorder (Services, except outpatient provider office visits, may require prior authorization.)		
Inpatient and residential services	30%	40%

✓ Deductible does not apply	Below is the amount you pay after you have met your calendar year Deductible In-Network	Out-of-Network
Mental Health and Substance Use Disorder (Services, except outpatient provider office visits, may require prior authorization.)		
Day treatment, intensive outpatient, and partial hospitalization services	30%	40%
Outpatient provider visits		40% ✓
In-Person	$20 ✓	
Virtually	$10 ✓	
Applied Behavior Analysis	30%	40%
Home Health and Hospice		
Home health care	30%	40%
Hospice care	Covered in full ✓	Covered in full ✓
Respite care (limited to Members receiving Hospice care; limited to 5 consecutive days, up to 30 days per lifetime)	30%	40%
Biofeedback		
Biofeedback for specified diagnosis (limited to 10 visits per lifetime)	30%	40%
Chiropractic Manipulation and Acupuncture (Massage therapy not covered)		
Chiropractic manipulations (limited to 20 visits per calendar year)	$25 ✓	50% ✓
Acupuncture (limited to 12 visits per calendar year)	$25 ✓	50% ✓

Prescription Drugs

Formulary P

✓ Deductible does not apply	Below is the amount you pay after you have met your calendar year Deductible
Up to a 30-Day Supply (From a participating retail, preferred or specialty pharmacy)	
Tier 1	Covered in full ✓
Tier 2	$10 ✓
Tier 3	$40 ✓
Tier 4	30% ✓
Tier 5	50% ✓ with $200 per script cap
Tier 6	50% ✓
90-Day Supply (From a participating preferred retail pharmacy)	
Tier 1	Covered in full ✓
Tier 2	$30 ✓
Tier 3	$120 ✓
Tier 4	30% ✓
90-Day Supply (From a participating mail order pharmacy)	
Tier 1	Covered in full ✓
Tier 2	$20 ✓
Tier 3	$80 ✓
Tier 4	25% ✓

Pharmacies

Your prescription drug benefit requires that you fill your prescriptions at a Participating Pharmacy. There are four types of participating pharmacies:

- Retail: a Participating Pharmacy that allows up to a 30-day supply as outlined in your handbook of short-term and maintenance prescriptions.
- Preferred Retail: a Participating Pharmacy that allows up to a 90-day supply of maintenance prescriptions and access to up to a 30-day supply of short-term prescriptions.
- Specialty: a Participating Pharmacy that allows up to a 30-day supply of specialty and self-administered chemotherapy prescriptions. These prescriptions require special delivery, handling, administration and monitoring by your pharmacist.
- Mail Order: a Participating Pharmacy that allows up to a 90-day supply of maintenance prescriptions and specializes in direct delivery to your home. To order prescriptions by mail, your provider may call in the prescription or you can mail your prescription along with your Member identification number to one of our participating mail-order pharmacies.
- View a list of our participating pharmacies ProvidenceHealthPlan.com/planpharmacies.

Using your prescription drug benefit

- To find if a drug is covered under your plan check online at ProvidenceHealthPlan.com/pharmacy. Note that your plan's formulary includes ACA Preventive drugs which are medications that are covered at no cost when received from participating pharmacies as required by the Patient Protection and Affordable Care Act.
- FDA-approved women's contraceptives, as listed on your formulary, are covered at no cost for up to a 12-month supply, after a 3-month initial fill, at any Participating Pharmacy.
- You may purchase up to a 90-day supply of maintenance drugs using a participating mail-service or preferred retail pharmacy. Not all drugs are considered maintenance prescriptions, including compounded drugs and drugs obtained from specialty pharmacies.
- If you or your provider request or prescribe a brand-name drug when a generic is available, regardless of reason, you will be responsible for the cost difference between the brand-name and generic drug in addition to the Tier 4 or Tier 6 copayment or coinsurance indicated on the benefit summary. Your total cost, however, will never exceed the actual cost of the drug.
- Approved non-formulary non-specialty drugs will be covered at the Tier 4 cost sharing tier. Approved non-formulary specialty drugs will be covered at the Tier 6 cost sharing tier.
- Compounded medications are prescriptions that are custom prepared by your pharmacist. They must contain at least one FDA-approved drug to be eligible for coverage under your plan. Compounded medications are covered for up to a 30-day supply at a 50% after the deductible. Claims are subject to clinical review for medical necessity and are not guaranteed for payment.

- Specialty drugs, which can be found in Tier 5 and Tier 6, are prescriptions that require special delivery, handling, administration and monitoring by your pharmacist.
- Most specialty and chemotherapy drugs are only available at our designated specialty pharmacies.
- Certain drugs, devices, and supplies obtained from your pharmacy may apply towards your medical benefit.
- Diabetes supplies may be obtained at your participating pharmacy, and are subject to your group's medical supplies and devices' benefit limitations, and Coinsurance. See your Member Handbook for details.
- Insulin cost share capped at $80 for a 30-day supply, $240 for a 90-day supply. Deductible does not apply.
- Some prescription drugs require Prior Authorization for medical necessity, place of therapy, length of therapy, step therapy, or number of doses. If a drug to treat your covered medical condition is not in the formulary, please contact us.
- Self-administered chemotherapy is covered under the Prescription Drug Benefit unless the Outpatient Chemotherapy coverage results in a lower out-of-pocket expense to you. Please refer to your Handbook for more information.
- Self-injectable medications are only covered when they are being self-administered and labeled by the FDA for self-administration; in some cases, a Prior Authorization may be required for the drug. Documentation of self-administration may also be required. Drugs labeled for self-administration that are being administered by a provider will fall to the Member's medical benefit.
- Be sure you present your current Providence Health Plan Member identification card.

Routine Vision Services
Provided by VSP

VSP Choice Network (For Customer Service call 800-877-7195) **✓ Deductible does not apply**	Below is the amount you pay after you have met your calendar year Deductible In-Network	Out-of-Network
Pediatric Vision Services (under age 19)		
Routine eye exam (limited to 1 exam per calendar year)	Covered in full ✓	Covered up to $45 ✓
Lenses (limited to 1 pair per calendar year)		
Single vision	Covered in full ✓	Covered up to $30 ✓
Lined bifocal	Covered in full ✓	Covered up to $50 ✓
Lined trifocal	Covered in full ✓	Covered up to $70 ✓
Lenticular lenses	Covered in full ✓	Covered up to $100 ✓
Frames (limited to 1 pair per calendar year; select from VSP's Otis & Piper ™ Eyewear Collection)	Covered in full ✓	Covered up to $70 ✓
Contact lens services and materials in place of glasses Standard: 1 pair per calendar year (1 contact lens per eye) Monthly: 6 month supply per calendar year (6 lenses per eye) Bi-weekly: 3 month supply per calendar year (6 lenses per eye) Dailies: 3 month supply per calendar year (90 lenses per eye)	Covered in full ✓	Covered up to $105 ✓
Adult Vision Services (Copayments do not apply to your Out-of-Pocket Maximum)		
Routine eye exam (limited to 1 exam per calendar year)	$30 ✓	Covered up to $45 ✓
Lenses (limited to 1 pair per calendar year)		
Single vision	Covered in full ✓	Covered up to $30 ✓
Lined bifocal	Covered in full ✓	Covered up to $50 ✓
Lined trifocal	Covered in full ✓	Covered up to $70 ✓
Lenticular lenses	Covered in full ✓	Covered up to $100 ✓
Progressive lenses	$50 ✓	Covered up to $50 ✓
Frames (limited to 1 pair per calendar year)	Covered up to $130 ✓	Covered up to $70 ✓
Contact lens services and materials in place of glasses (limited to every calendar year)	Covered up to $130 ✓	Covered up to $105 ✓

Pediatric Dental Service (under age 19)

For Customer Service, including dental Prior Authorizations and claims, call 800-878-4445. **✓ Deductible does not apply**	Below is the amount you pay after you have met your calendar year Deductible In-Network	Out-of-Network If you choose to go outside the dental network, you may be subject to billing for charges that are above the Maximum Allowable Charge (MAC).
Preventive		
Routine Exams Two per every 12 months	Covered in full ✓	30% ✓
Bitewing X-rays Four per every 6 months	Covered in full ✓	30% ✓
Cleanings One per every 6 months	Covered in full ✓	30% ✓
Topical Fluoride One per every 6 months	Covered in full ✓	30% ✓
Fissure sealants One service per tooth (molar) per every 60 months	Covered in full ✓	30% ✓
Space Maintainers	Covered in full ✓	30% ✓
Basic		
Restorative fillings	50%	70%
Major		
Oral surgery (extractions and other minor surgical procedures)	50%	70%
Endodontics and Periodontics	50%	70%
Stainless Steel Crowns/Anterior Primary or Posterior Primary/Permanent One service per tooth in a 7-year period	50%	70%
Porcelain Crowns One service per tooth in a 7-year period for children ages 16 and older (limited to tooth numbers 6-11, 22 and 27 only)	50%	70%
Denture and bridge work (construction or repair of fixed bridges, partials and complete dentures) Limited to 1 every 10 years for complete dentures and 1 every 10 years for partials for Members ages 16 and older	50%	70%

Explanation of terms and phrases

ACA Preventive Drugs - ACA Preventive drugs are medications, including contraceptives, which are listed in our formulary, and are covered at no cost when received from Participating Pharmacies as required by the Patient Protection and Affordable Care Act (ACA). Over the counter preventive drugs received from Participating Pharmacies cannot be covered in full without a written prescription from your Qualified Practitioner.

Brand-name drugs - Brand-name drugs are protected by U.S. patent laws and only a single manufacturer has the rights to produce and sell them.

Coinsurance - The percentage of the cost that you may need to pay for Covered Service.

Copay - The fixed dollar amount you pay to a healthcare provider for a Covered Service at the time care is provided.

Deductible - The dollar amount that an individual or family pays for Covered Service before the plan pays any benefits within a Calendar Year. The following expenses do not apply to the individual or family deductible: Services not covered by the plan; fees that exceed Usual, Customary and Reasonable (UCR) charges as established by the plan; penalties incurred if you do not follow the plan's Prior Authorization requirements; copays and Coinsurance for Services that do not apply to the deductible.

NOTE: No Member will ever pay more than an Individual Deductible before the Plan begins paying for covered services for that Member.

Formulary - A formulary is a list of FDA-approved prescription drugs developed by physicians and pharmacists, designed to offer effective drug treatment choices for covered medical conditions. The Providence Health Plan formulary includes both brand-name and generic medications.

Generic drugs - Generic drugs have the same active-ingredient formula as the brand-name drug. Generic drugs are usually available after the brand-name patent expires.

In-Network - Refers to Services received from an extensive network of highly qualified physicians, health care providers and facilities contracted by Providence Health Plan for your specific plan. Generally, your Out-of-Pocket costs will be less when you receive Covered Service from In-Network Providers.

Limitations and Exclusions - All Covered Services are subject to the limitations and exclusions specified for your plan. Refer to your Member handbook or contract for a complete list.

Maintenance Prescriptions - Medications that are typically prescribed to treat long-term or chronic conditions, such as diabetes, high blood pressure and high cholesterol. Maintenance drugs are those that you have received under our plan for at least 30 days and that you anticipate continuing to use in the future. Compounded and specialty medications are excluded from this definition; and are limited to a 30 day supply.

Maximum Allowable Charge (MAC) - A limitation on the billed charges as determined by Providence Health Plan or its authorizing agent by geographic area where the expenses are incurred and may not be less than the negotiated fee for the same Service when provided by a Network Dental Provider. MAC charges do not include sales taxes, handling fees and similar surcharges, and such taxes, fees and surcharges are not covered expenses.

Medicare Part D creditable

Medicare Part D creditable - Coverage is creditable when the plan payout for prescription drugs is, on average for all plan participants, as much as the average payout under the standard Medicare Part D benefit.

Not Medicare Part D creditable - Coverage is non-creditable when the plan payout for prescription drugs is, on average for all plan participants, less than what standard Medicare Part D prescription drug coverage would be expected to pay.

Non-Formulary Medication - An FDA-approved drug, generic or brand-name, that is not included in the list of approved formulary medications. These prescriptions require a Prior Authorization by the health plan and, if approved, will pay at either the highest non-specialty or specialty cost sharing tier.

Office Visits Virtually - Scheduled visits with the member's PCP or Specialist using a teleconferencing application such as Zoom.

Out-of-Network - Refers to Services you receive from providers not in your plan's network. Your Out-of-Pocket costs are generally higher when you receive Covered Services outside of your plan's network. An Out-of-Network Provider does not have contracted rates with Providence Health Plan and so balance billing may apply. To find an In-Network Provider, go to ProvidenceHealthPlan.com/findaprovider.

Out-of-Pocket Maximum - The limit on the dollar amount that an individual or family pays for specified Covered Services in a Calendar Year. Some Services and expenses do not apply to the individual or family Out-of-Pocket Maximum. See your Member handbook or contract for details.

NOTE: Once any Member meets the Individual Out-of-Pocket Maximum, the Plan will begin to pay 100% for Covered Services for that Member.

Primary Care Provider - A qualified physician or practitioner that can provide most of your care and, when necessary, will coordinate care with other providers in a convenient and cost-effective manner.

Prescription drug Prior Authorization - The process used to request an exception to the Providence Health Plan drug formulary. A Prior Authorization can be requested by the prescriber, member or pharmacy. Some drugs require Prior Authorization for Medical Necessity, place of therapy, length of therapy, step therapy or number of doses. Visit us online for additional information at ProvidenceHealthPlan.com.

Prescription drug Tier - The prescription drug tier number correlates to a drug's placement on the formulary. Tier 1 and Tier 2 consists of mainly generic drugs while Tier 3 and Tier 4 contains both generic and brand-name drugs. Specialty drugs are listed in Tier 5 and Tier 6.

Prior Authorization - Some Services must be pre-approved. In-Network, your provider will request Prior Authorization. Out-of-Network, you are responsible for obtaining Prior Authorization.

Providence ExpressCare Virtual - Services for common conditions (such as sore throat, cough, or fever, etc.) using Providence's web-bases platform through a tablet, smartphone, or computer for same day appointments.

Providence ExpressCare Retail Health Clinic - A walk-in health clinic, other than an office, Urgent Care facility, pharmacy or independent clinic that is located within a retail operation. A Retail Health Clinic provides same-day visits for basic illness and injuries or preventive services.

Explanation of terms and phrases

Specialty Drugs - Specialty drugs are injectable, infused, oral, topical, or inhaled therapies that often require specialized delivery, handling, monitoring and administration and are generally high cost. These drugs must be purchased through our designated specialty pharmacy. Due to the nature of these medications, specialty drugs are limited to a 30-day supply. Your benefits include specialty drugs listed on our formulary in Tier 5 and Tier 6. Generally your out-of-pocket costs will be less for Tier 5 drugs.

Usual, Customary & Reasonable (UCR) - Describes your plan's allowed charges for Services that you receive from an Out-of-Network Provider. When the cost of Out-of-Network Services exceeds UCR amounts, you are responsible for paying the provider any differences. These amounts do not apply to your Out-of-Pocket Maximums.

Contact us

Portland Metro Area: 503-574-7500
All other areas: 800-878-4445
TTY:711

ProvidenceHealthPlan.com/contactus

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
  - Written information 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://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៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល 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).

توجه: اگر به زبان فارسی گفتگو می‌کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می‌باشد. با 1-800-878-4445 (TTY: 711) تماس بگیرید.

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)

Notes