



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, go to <https://regence.com> or call 1 (800) 262-9712. 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 (800) 262-9712 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network provider: \$275 individual / \$550 family per plan year. Out-of-network provider: \$500 individual / \$1,000 family per plan year.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Certain <u>preventive care</u> and those services listed below as " <u>deductible</u> does not apply." "No charge" means \$0 <u>copayment</u> or 0% <u>coinsurance</u> , regardless of <u>deductible</u> applicability.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. \$55 individual / \$110 family per plan year for <u>prescription drug coverage</u> . There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-network provider: \$2,625 individual / \$5,250 family per plan year. Out-of-network provider: \$5,000 individual / \$10,000 family per plan year.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>prescription drug cost sharing</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See https://regence.com/go/UT/PVCU or call 1 (800) 262-9712 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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
		University of Utah Health Provider / Primary Children's Hospital / Granger Medical Clinic (You pay the least)	In-Network Provider (You pay more)	Out-of-Network 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	<p>\$25 <u>copay</u> / office visit, <u>deductible</u> does not apply;</p> <p>No charge, <u>deductible</u> does not apply for radiology, laboratory and pathology services;</p> <p>15% <u>coinsurance</u> for other services</p>	<p>\$40 <u>copay</u> / office visit, <u>deductible</u> does not apply;</p> <p>No charge, <u>deductible</u> does not apply for radiology, laboratory and pathology services;</p> <p>20% <u>coinsurance</u> for other services</p>	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	<p>\$25 <u>copay</u> / office visit, <u>deductible</u> does not apply;</p> <p>No charge, <u>deductible</u> does not apply for radiology, laboratory and pathology services;</p> <p>15% <u>coinsurance</u> for other services</p>	<p>\$40 <u>copay</u> / office visit, <u>deductible</u> does not apply;</p> <p>No charge, <u>deductible</u> does not apply for radiology, laboratory and pathology services;</p> <p>20% <u>coinsurance</u> for other services</p>	40% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	No charge, <u>deductible</u> does not apply	No charge, <u>deductible</u> does not apply	40% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		University of Utah Health Provider / Primary Children's Hospital / Granger Medical Clinic (You pay the least)	In-Network Provider (You pay more)	Out-of-Network Provider (You pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	15% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	15% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://realrxhealth.com/?link=RLRXUUCMESA3001	Tier 1 (Typically, generic drugs with highest overall value)	University of Utah Health Care Pharmacy: 20% <u>coinsurance</u> , <u>deductible</u> does not apply (\$7 minimum / \$150 maximum)	25% <u>coinsurance</u> , <u>deductible</u> does not apply (\$7 minimum / \$250 maximum)	25% <u>coinsurance</u> , <u>deductible</u> does not apply (\$7 minimum / \$250 maximum)	Your <u>prescription drug coverage</u> is administered through RealRx. RealRx does not provide Blue Cross Blue Shield services and is a separate company solely responsible for its products and services. Regence BlueCross BlueShield of Utah assumes no liability for the accuracy of your <u>prescription drug</u> benefits information. <u>Prescription drugs</u> not on the Drug List are not covered, unless an exception is approved. <u>Deductible</u> does not apply for tier 1 drugs and tier 2 insulin. <u>Prescription drug out-of-pocket limit</u> : \$2,625 individual / \$5,250 family per plan year. 90-day supply / retail or home delivery prescription (your <u>cost share</u> is per 30-day supply) 30-day supply / self-administrable cancer chemotherapy drugs 30-day supply / <u>specialty drug</u> prescription Coverage includes diabetic supplies (\$7 minimum / \$150 maximum) and compound medications (\$7 minimum / \$250 maximum) at 20% <u>coinsurance</u> /
	Tier 2 (Typically, brand drugs with moderate overall value)	University of Utah Health Care Pharmacy: 20% <u>coinsurance</u> (\$7 minimum / \$200 maximum)	25% <u>coinsurance</u> (\$7 minimum / \$250 maximum)	25% <u>coinsurance</u> (\$7 minimum / \$250 maximum)	
	Tier 3 (Typically, brand drugs with lower overall value)	University of Utah Health Care Pharmacy: 40% <u>coinsurance</u> (\$7 minimum / \$400 maximum)	40% <u>coinsurance</u> (\$7 minimum / \$400 maximum)	40% <u>coinsurance</u> (\$7 minimum / \$400 maximum)	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		University of Utah Health Provider / Primary Children's Hospital / Granger Medical Clinic (You pay the least)	In-Network Provider (You pay more)	Out-of-Network Provider (You pay the most)	
	Tier 4 (<u>Specialty drugs</u>)	University of Utah Health Care Pharmacy: 20% <u>coinsurance</u> (\$7 minimum / \$300 maximum)	35% <u>coinsurance</u> (\$7 minimum / \$500 maximum)	35% <u>coinsurance</u> (\$7 minimum / \$500 maximum)	30-day supply. <u>Cost shares</u> for tier 2 insulin will not exceed \$25 / 30-day supply retail prescription or \$75 / 90-day supply home delivery prescription. No charge, <u>deductible</u> does not apply for certain preventive drugs, contraceptives (including emergency contraceptive for tier 1 and tier 2) and immunizations at a participating pharmacy. Medications used as part of an outpatient cancer drug treatment regimen that is provided and dispensed in a professional setting will be subject to these prescription benefits. If you fill a brand drug or <u>specialty drug</u> when there is an equivalent generic drug or specialty biosimilar drug available, you pay the difference in cost in addition to the <u>copayment</u> and/or <u>coinsurance</u> . The first fill of <u>specialty drugs</u> may be provided by a retail pharmacy; additional refills must be provided by a specialty pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	15% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>copay</u> / visit, <u>deductible</u> does not apply	\$200 <u>copay</u> / visit, <u>deductible</u> does not apply	\$200 <u>copay</u> / visit, <u>deductible</u> does not apply	<u>Copayment</u> applies to facility charge for each visit (waived if admitted).
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Out-of-network provider services</u> apply to the in-network <u>deductible</u> and in-network <u>out-of-pocket limit</u> .

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		University of Utah Health Provider / Primary Children's Hospital / Granger Medical Clinic (You pay the least)	In-Network Provider (You pay more)	Out-of-Network Provider (You pay the most)	
	<u>Urgent care</u>	\$40 <u>copay</u> / visit, <u>deductible</u> does not apply; No charge, <u>deductible</u> does not apply for radiology, laboratory and pathology services; 15% <u>coinsurance</u> for other services	\$40 <u>copay</u> / visit, <u>deductible</u> does not apply; No charge, <u>deductible</u> does not apply for radiology, laboratory and pathology services; 20% <u>coinsurance</u> for other services	40% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	15% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	15% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Contact HMHI Behavioral Health Network at (801) 587-9319, (801) 262-9619 or (800) 926-9619 for your mental health, behavioral health or substance abuse coverage.			Your mental health, behavioral health or substance abuse coverage is administered through HMHI Behavioral Health Network. Regence BlueCross BlueShield of Utah assumes no liability for the accuracy of your mental health, behavioral health or substance abuse benefit information.
	Inpatient services				
If you are pregnant	Office visits	15% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Adoption coverage is limited to \$4,000 / per qualified pregnancy. The adoption indemnity benefit is not exchangeable for infertility treatment benefits. <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services
	Childbirth/delivery professional services	15% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	15% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		University of Utah Health Provider / Primary Children's Hospital / Granger Medical Clinic (You pay the least)	In-Network Provider (You pay more)	Out-of-Network Provider (You pay the most)	
					described elsewhere in the SBC (i.e. ultrasound).
If you need help recovering or have other special health needs	Home health care	15% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Rehabilitation services	\$25 <u>copay</u> / outpatient visit, <u>deductible</u> does not apply; 15% <u>coinsurance</u> for inpatient services	\$40 <u>copay</u> / outpatient visit, <u>deductible</u> does not apply; 20% <u>coinsurance</u> / inpatient services	40% <u>coinsurance</u>	30 inpatient days / year Includes physical therapy, occupational therapy and speech therapy.
	Habilitation services	\$25 <u>copay</u> / visit, <u>deductible</u> does not apply	\$40 <u>copay</u> / visit, <u>deductible</u> does not apply	40% <u>coinsurance</u>	\$5,000 physical therapy / year \$5,000 occupational therapy / year \$5,000 speech therapy / year
	Skilled nursing care	15% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Durable medical equipment	20% <u>coinsurance</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	Hospice services	15% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	14 respite inpatient or outpatient days / lifetime
If your child needs dental or eye care	Children's eye exam	\$25 <u>copay</u> / visit, <u>deductible</u> does not apply	\$40 <u>copay</u> / visit, <u>deductible</u> does not apply	40% <u>coinsurance</u>	Limited to 1 routine examination / year Examination does not include contact lens fitting.
	Children's glasses	Not covered	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Exclusion Examples

The following examples of limitations and exclusions are included to illustrate the types of conditions, treatments, services, supplies or accommodations that may not be covered under your plan, including related secondary medical conditions and are not all inclusive:

- a charge in connection with reconstructive or plastic surgery that may have a limited benefit, such as a chemical peel that does not alleviate a functional impairment;
- a complication relating to services and supplies for, or in connection with: gastric or intestinal bypass; gastric stapling; a similar surgical procedure to facilitate weight loss; or a procedure related to the reversal or revision, or any direct complications or consequences of one of these procedures;
- a complication due to infection from a cosmetic procedure, except in a case of reconstructive surgery:

- when the service is incidental to or follows a surgery resulting from trauma, infection or other disease of the involved part; or
- related to a congenital disease or anomaly of a covered dependent child that has resulted in functional defect; or
- a complication that results from an injury or illness resulting from voluntary participation in an illegal activity as described by Utah Admin. Code R590-277-4.

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

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|---|---|---|
| • Abortion (except in cases of rape, incest or to avert the death of the enrolled individual) | • Cosmetic surgery, except congenital anomalies | • Routine foot care, except for diabetic patients |
| • Acupuncture | • Long-term care | • Weight loss programs |
| | • Private-duty nursing | |

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

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|--|---|-----------------------------|
| • Bariatric surgery, 1 surgery / lifetime | • Infertility treatment, \$13,000 / lifetime; additional \$7,500 / lifetime for fertility preservation services | • <u>Prescription drugs</u> |
| • Chiropractic care, 20 spinal manipulations | • Non-emergency care when traveling outside the U.S. | • Routine eye care |
| • Dental care | | |
| • Hearing aids, 1 per ear / every 2 plan years | | |

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 (800) 262-9712. 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 (800) 262-9712 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 Utah Department of Insurance by calling 1 (801) 957-9200 or the toll-free message line at 1 (800) 439-3805; by writing to the Utah Department of Insurance, 4315 S 2700 W, Suite 2300, Taylorsville, UT 84129; through the Internet at: www.insurance.utah.gov/health/independent-review; or by E-mail at: healthappeals@utah.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:

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1 (800) 262-9712.

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** \$275
- **Specialist copayment** \$40
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,400
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,685

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

- **The plan's overall deductible** \$275
- **Specialist copayment** \$40
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$200
The total Joe would pay is	\$1,700

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

- **The plan's overall deductible** \$275
- **Specialist copayment** \$40
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,100

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

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 less favorably because of race, color, national origin, age, disability, or sex.

Regence:

Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:

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

Provides free language assistance services to people whose primary language is not English, which may include:

- Qualified interpreters
- Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Civil Rights Coordinator.

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. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

Customer Service

Civil Rights Coordinator
PO Box 1106
Lewiston, ID 83501-1106
Phone: 1-888-344-6347, (TTY: 711)
Fax: 1-888-309-8784
Email: CS@regence.com

Medicare Customer Service

Phone: 1-800-541-8981 (TTY: 711)
Email: medicareappeals@regence.com

VSP Customer Service

Phone: 1-844-299-3041
TTY: 1-800-428-4833

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, D.C. 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'déé', t'áá jiik'eh, éí ná hóló, koji' 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 ដោយមិនគិតល្អល 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)

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ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-344-6347 (TTY: 711)

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توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-344-6347 (TTY: 711) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذاكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم 711 TTY)