Notice: Your Rights and Protections Against Surprise Medical Bills

When You get emergency care or are treated by an out-of-network Provider at an in-network Hospital or Ambulatory Surgical Center, You are protected from balance billing. In these cases, You shouldn't be charged more than Your plan's Copayments, Coinsurance and/or Deductible.

WHAT IS "BALANCE BILLING" (SOMETIMES CALLED "SURPRISE BILLING")?

When You see a doctor or other health care Provider, You may owe certain out-of-pocket costs, like a Copayment, Coinsurance, or Deductible. You may have additional costs or have to pay the entire bill if You see a Provider or visit a health care facility that isn't in Your health plan's network.

"Out-of-network" as used in this Notice, means Providers and facilities that haven't signed a contract with Your health plan to provide services. Out-of-network Providers may be allowed to bill You for the difference between what Your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward Your plan's Deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when You can't control who is involved in Your care - like when You have an emergency or when You schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network Provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

YOU ARE PROTECTED FROM BALANCE BILLING FOR:

Emergency services

If You have an Emergency Medical Condition and get emergency services from an out-of-network Provider or facility, the most they can bill You is Your plan's in-network cost-sharing amount (such as Copayments, Coinsurance, and Deductibles). You **can't** be balance billed for these emergency services. This includes services You may get after You're in stable condition, unless You give written consent and give up Your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network Hospital or Ambulatory Surgical Center

When You get services from an in-network Hospital or Ambulatory Surgical Center, certain Providers there may be out-of-network. In these cases, the most those Providers may bill You is Your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These Providers **can't** balance bill You and may **not** ask You to give up Your protections not to be balance billed.

If You get other types of services at these in-network facilities, out-of-network Providers **can't** balance bill You, unless You give written consent and give up Your protections.

You're <u>never</u> required to give up Your protections from balance billing. You also aren't required to get care out-of-network. You can choose a Provider or facility in Your plan's network.

WHEN BALANCE BILLING ISN'T ALLOWED, YOU ALSO HAVE THESE PROTECTIONS:

- You are only responsible for paying Your share of the cost (like the Copayments, Coinsurance, and Deductibles that You would pay if the Provider or facility was in-network). Your health plan will pay any additional costs to out-of-network Providers and facilities directly.
- Generally, Your health plan must:
    - Cover emergency services without requiring You to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network Providers.
    - Base what You owe the Provider or facility (cost-sharing) on what it would pay an in-network Provider or facility and show that amount in Your explanation of benefits.
    - Count any amount You pay for emergency services or out-of-network services toward Your in-network Deductible and out-of-pocket limit.

If You believe You've been wrongly billed by Us, contact the Oregon Division of Financial Regulation by:

- calling the Consumer Hotline at 1 (888) 877-4894;
- e-mail at: **DFR.InsuranceHelp@dcbs.oregon.gov**; or
- filing a complaint at: **https://dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx**.

If You believe You've been wrongly billed by a Provider, contact **www.cms.gov/nosurprises/consumers** or call the No Surprises Help Desk at 1 (800) 985-3059.

Visit **www.cms.gov/nosurprises/consumers** for more information about Your rights under federal law.

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/go/2023/policy/OR/StandardSilverIFNEx or call 1 (888) 675-6570. 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 (888) 675-6570 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$4,800 individual / $9,600 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 coinsurance 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$9,100 individual / $18,200 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?	Pediatric vision services, 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/OR/IFN or call 1 (888) 675-6570 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network 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 an out-of-network 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 **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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 copay / office visit, deductible does not apply; 30% coinsurance for all other services	Not covered	Copayment applies to each in-network office visit only. All other services are covered at the coinsurance specified, after deductible. Acupuncture services are subject to $40 copayment / visit, deductible does not apply. 12 acupuncture visits / year Spinal manipulations are subject to $40 copayment / visit, deductible does not apply. 20 spinal manipulation visits / year
	Specialist visit	$80 copay / office visit, deductible does not apply; 30% coinsurance for all other services	Not covered	
	Preventive care/screening/ immunization	No charge	Not covered	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.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://regence.com/go/2023/OR/6tier	Preferred generic drugs & generic drugs	$15 copay / preferred retail prescription $45 copay / preferred home delivery prescription 25% coinsurance / retail prescription 25% coinsurance / home delivery prescription	Not covered	Prescription drugs not on the Drug List are not covered, unless an exception is approved. Deductible does not apply. 90-day supply / retail prescription (your cost share is per 30-day supply) 90-day supply / home delivery (mail order) prescription 30-day supply / specialty drug prescription Specialty drugs are not available through home delivery (mail order). Cost shares for insulin will not exceed $80 / 30-day supply retail prescription or $240 / 90-day supply home delivery (mail order) prescription. No charge for certain preventive drugs, contraceptives and immunizations at a participating pharmacy. If you fill a brand drug or specialty drug when there is an equivalent generic drug or specialty biosimilar drug
	Preferred brand drugs	$60 copay / retail prescription $180 copay / home delivery prescription	Not covered	
	Brand drugs	50% coinsurance / retail prescription 50% coinsurance / home delivery prescription	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Preferred specialty drugs & specialty drugs	40% coinsurance / preferred specialty drug 50% coinsurance / specialty drug	Not covered	available, you pay the difference in cost in addition to the copayment and/or coinsurance. The first fill of specialty drugs may be provided by a retail pharmacy; additional refills must be provided by a specialty pharmacy. Coverage for self-administrable cancer chemotherapy drugs is 30% coinsurance.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not covered	None
	Physician/surgeon fees	30% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	None
	Emergency medical transportation	30% coinsurance	30% coinsurance	None
	Urgent care	$70 copay / office visit, deductible does not apply; 30% coinsurance for all other services	$70 copay / office visit, deductible does not apply; 30% coinsurance for all other services	Copayment applies to each in-network or out-of-network office visit only. All other services are covered at the coinsurance specified, after deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not covered	None
	Physician/surgeon fees	30% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 copay / office visit, deductible does not apply; 30% coinsurance for all other services	Not covered	Copayment applies to each in-network office/psychotherapy visit only. All other services are covered at the coinsurance specified, after deductible.
	Inpatient services	30% coinsurance	Not covered	None
If you are pregnant	Office visits	30% coinsurance	Not covered	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	30% coinsurance	Not covered	
	Childbirth/delivery facility services	30% coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Not covered	None
	Rehabilitation services	$40 copay / office visit, deductible does not apply; 30% coinsurance for all other services	Not covered	30 inpatient days (up to 60 days for head or spinal cord injury) each for rehabilitation and habilitation services / year 30 outpatient visits each for rehabilitation and habilitation services / year Copayment applies to each in-network outpatient visit only. All inpatient services are covered at the coinsurance specified, after deductible. Includes physical therapy, occupational therapy and speech therapy.
	Habilitation services	$40 copay / office visit, deductible does not apply; 30% coinsurance for all other services	Not covered	
	Skilled nursing care	30% coinsurance	Not covered	60 inpatient days / year
	Durable medical equipment	30% coinsurance	Not covered	1 synthetic wig / year 1 pair of glasses or contacts / year for individuals with severe medical or surgical problems other than refractive procedures
	Hospice services	30% coinsurance	Not covered	30 respite inpatient or outpatient days / lifetime Respite limited to 5 consecutive days at a time.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	1 routine eye examination / year for individuals under age 19 VSP doctors are the only in-network providers.
	Children's glasses	No charge	Not covered	1 pair of lenses / year 1 set of frames / year Glasses limited to individuals under age 19. Frames from VSP doctors are limited to Otis & Piper Eyewear Collection. VSP doctors are the only in-network providers.
	Children's dental check-up	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.)

- Bariatric surgery
- Cosmetic surgery, except congenital anomalies
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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.)

- Abortion (Laws prohibit public funding of certain covered terminations of pregnancy. Premium payments are segregated to ensure compliance.)
- Acupuncture
- Chiropractic care, spinal manipulations only
- Hearing aids

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 (888) 675-6570. 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 (888) 675-6570 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 Oregon Division of Financial Regulation by calling 1 (503) 947-7984 or the toll-free message line at 1 (888) 877-4894; by writing to the Oregon Division of Financial Regulation, Consumer Advocacy Unit, P.O. Box 14480, Salem, OR 97309-0405; through the Internet at: dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx; or by E-mail at: DFR.InsuranceHelp@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 1 (888) 675-6570.

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	**$4,800**
Specialist copayment	**$80**
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	
Deductibles	$4,800
Copayments	$11
Coinsurance	$2,225
What isn't covered	
Limits or exclusions	$61
The total Peg would pay is	**$7,097**

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

The plan's overall deductible	**$4,800**
Specialist copayment	**$80**
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	
Deductibles	$877
Copayments	$1,239
Coinsurance	$0
What isn't covered	
Limits or exclusions	$178
The total Joe would pay is	**$2,294**

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

The plan's overall deductible	**$4,800**
Specialist copayment	**$80**
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	
Deductibles	$2,090
Copayments	$405
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,495**

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

VSP is a separate company that provides vision benefit 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 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:

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)።

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-344-6347 (телетайп: 711)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-344-6347 (टिटिवाइ: 711

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

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-344-6347 (TTY: 711)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-344-6347 (TTY: 711)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-344-6347 (TTY: 711)

Afaan dubbattan Oroomiffaa tiif, tajaajila gargaarsa afaanii tola ni jira. 1-888-344-6347 (TTY: 711) tiin bilbilaa.

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