Your Benefit Summary

Option Advantage Plus (A)

Pacific Northwest Consulting Engineers Health & Welfare Trust
Plan 10 Value

PROVIDENCE Health Plan

Copay	What You Pay In-Network	What You Pay Out-of-Network	Calendar Year In-Network Out-of-Pocket Maximum	Calendar Year Out-of-Network Out-of-Pocket Maximum	Calendar Year In-Network Deductible	Calendar Year Out-of-Network Deductible
$25/$35	30% coinsurance (after deductible)	50% coinsurance (after deductible; UCR applies)	$4,250 per person $8,500 per family (2 or more)	$8,500 per person $17,000 per family (2 or more)	$1,000 per person $2,000 per family (2 or more)	$2,000 per person $4,000 per family (2 or more)

Important information about your plan

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

- The individual deductible applies if there are no dependents enrolled. If two or more members are enrolled, the individual deductible applies for each member only until the family deductible is met.
- The individual out-of-pocket maximum applies if there are no dependents enrolled. If two or more members are enrolled, the individual out-of-pocket applies for each member only until the family out-of-pocket is met.
- Your deductible(s) are included in the out-of-pocket maximum amount(s) listed above.
- In-network and out-of-network services accumulate separately.
- Some services and penalties do not apply to out-of-pocket maximums.
- Prior authorization is required for some services.
- To get the most out of your benefits, use the providers within the Providence Signature network. View a list of network providers and pharmacies at http://phppd.providence.org.
- 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 to your benefits. See your Member Handbook for details.

Option Advantage Plus (A) Benefit Highlights

✓ No deductible needs to be met prior to receiving this benefit.	After you pay your calendar year deductible(s), then you pay the following for covered services: In-Network Copay or Coinsurance (after deductible, when you see an in-network provider)	Out-of-Network Copay or Coinsurance (after deductible, when you see a non-network provider)
On-Demand Provider Visits		
• Virtual visits to a Primary Care Provider by phone & video (ExpressCare Virtual) or by Web-direct Visits (where available)	Covered in full✓	Not covered
• Providence ExpressCare Retail Health Clinic	Covered in full✓	Not applicable
• Virtual visits to a Specialist by phone & video	$20 / visit✓	Not covered
Preventive Care		
• Periodic health exams and well-baby care	Covered in full✓	50%✓
• Colonoscopy (age 50 +)	Covered in full✓	50%
• Routine immunizations; shots	Covered in full✓	50%
• Gynecological exam (calendar year) and PAP test	Covered in full✓	50%✓
• Mammograms	Covered in full✓	50%
• Nutritional counseling	Covered in full✓	50%✓
• Tobacco cessation, counseling/classes and deterrent medications	Covered in full✓	Not covered
Physician / Provider Services		
• Office visits to Primary Care Provider	$25 / visit✓	50%✓
• Office visits to Alternative Care Provider (such as Naturopath) (Chiropractic manipulation & acupuncture services are covered only if a separate benefit has been purchased by your employer. Consult your member materials for these benefits.)	$25 / visit✓	50%✓
• Office visits to Specialists/Other Providers	$35 / visit✓	50%✓
• Allergy shots and serums	30%✓	50%
• Infusions and injectable medications	30%	50%
• Surgery; anesthesia in an office or facility	30%	50%
• Inpatient hospital visits	30%	50%

Option Advantage Plus (A) Benefit Highlights (continued)	In-Network Copay or Coinsurance	Out-of-Network Copay or Coinsurance
Diagnostic Services		
• X-ray, lab services, and testing services (includes ultrasound) (Covered in full, deductible waived, for the first $500 of in-network services in a calendar year, then deductible and coinsurance.)	30%	50%
• High-tech imaging services (such as PET, CT or MRI)	30%	50%
Emergency and Urgent Services		
• Emergency services (For emergency medical conditions only. If admitted to hospital, copayment is not applied; all services subject to inpatient benefits.)	$350	$350
• Urgent care services (for non-life threatening illness/minor injury)	$35 / visit✓	50%
• Emergency medical transportation (air and/or ground) (Emergency medical transportation is covered under your in-network benefit, regardless of whether or not the provider is an in-network provider)	30%	30%
Hospital Services		
• Inpatient/Observation care	30%	50%
• Rehabilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)	30%	50%
• Habilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)	30%	50%
• Skilled nursing facility (Limited to 60 days per calendar year)	30%	50%
• Temporomandibular joint (TMJ) services (Inpatient and/or outpatient services combined limit of $1,000 per calendar year/$5,000 per lifetime)	50%	Not covered
Outpatient Services		
• Outpatient surgery, infusion, dialysis, chemotherapy, radiation therapy (Prior authorization required for outpatient hospital-based infusions)	30%	50%
• Outpatient Surgery at an Ambulatory Surgical Center (ASC)	20%	50%
• Temporomandibular joint (TMJ) service (Inpatient and/or outpatient services combined limit of $1,000 per calendar year/$5,000 per lifetime)	50%	Not covered
• Colonoscopy (Non-preventive) at a Hospital-based facility	30%	50%
• Colonoscopy (Non-preventive) at an Ambulatory Surgical Center (ASC)	20%	50%
• Outpatient rehabilitative services: physical, occupational, and speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services)	30%✓	50%
• Outpatient habilitative services: physical, occupational and speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.)	30%✓	50%
• Cardiac rehabilitation (In-network, first 16 visits covered in full, deductible waived, then deductible and coinsurance)	30%	50%
Maternity Services		
• Prenatal office visits	Covered in full✓	50%
• Delivery and postnatal services	30%	50%
• Inpatient hospital/facility services	30%	50%
• Routine newborn nursery care	30%	50%
Medical Equipment, Supplies and Devices		
• Medical equipment, appliances, prosthetics/orthotics and supplies (Hearing aids limited to 1 per ear every 3 calendar years)	30%	50%
• Diabetes supplies (such as lancets, test strips and needles)	30%✓	50%
• Removable custom shoe orthotics (Limited to $200 per calendar year)	30%✓	50%✓
• Oral Sleep Apnea Appliance (Out-of-Network limited to $2,000 per calendar year)	30%	50%
Mental Health / Chemical Dependency (All services, except outpatient provider office visits, must be prior authorized. For information, please call 800-711-4577.)		
• Inpatient and residential services	30%	50%
• Day treatment, intensive outpatient and partial hospitalization services	30%	50%
• Applied behavior analysis	30%	50%
• Outpatient provider office visits	$25 / visit✓	50%✓
Home Health and Hospice		
• Home health care	30%	50%
• Hospice care	Covered in full✓	Covered in full✓

Option Advantage Plus (A) Benefit Highlights (continued)	In-Network Copay or Coinsurance	Out-of-Network Copay or Coinsurance
Routine Vision Exam		
Provided by VSP		
VSP Choice Network (for Customer Service call 800-877-7195)		
Your copays do not apply to your plan's medical out-of-pocket maximums		
• Pediatric WellVision Exam® (under age 19) - Every 12 months	Covered in full✓	Covered up to $45✓
• Adult WellVision Exam® - Every 12 months	$10✓	Covered up to $45✓

Your guide to the words or phrases used to explain your benefits

Coinsurance
The percentage of the cost that you may need to pay for a covered service.

Deductible
The dollar amount an individual or family pays for covered services before your plan pays any benefits within a calendar year. Your plan has both in-network and an out-of-network deductibles. These deductibles accumulate separately and are not combined. The following expenses do not apply to an individual or family deductible:

- Services not covered by your plan.
- Fees that exceed usual, customary and reasonable (UCR) charges as established by your plan.
- Penalties incurred if you do not follow your plan's prior authorization requirements.
- Copays and coinsurance for services that do not apply to the deductible

Copay
The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

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

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 ervices 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.

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 http://phppd.providence.org.

Out-of-Pocket Maximum
The limit on the dollar amount that an individual or family pays for specified covered services in a plan year. This plan has both in-network and out-of-network out-of-pocket maximums. These out-of-pocket maximums accumulate separately and are not combined. Some services and expenses do not apply to the individual or family out-of-pocket maximum. See your member handbook for details

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.

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.

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.

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 difference. These amounts do not apply to your out-of-pocket maximums.

Virtual visit
Visit with a Network Provider using secure internet technology such as Providence Express Care phone and video visits or Web-direct Visits.

Web-direct Visit
A consultation with Network Provider using an online questionnaire to collect information to diagnose and treat common conditions such as cold, flu, sore throat, allergies, earaches, sinus pain or UTI.

Contact us
Headquartered in Portland, our customer service professionals have been proudly serving our members since 1986.

Portland Metro Area: 503-574-7500
All other areas: 800-878-4445
TTY: 503-574-8702 or 888-244-6642

Have questions about your benefits and want to contact us via e-mail? Go to our Web site at:
www.ProvidenceHealthPlan.com/contactus

Your Benefit Summary

Chiropractic Manipulation and Acupuncture

Pacific Northwest Consulting Engineers Health & Welfare Trust

PROVIDENCE Health Plan

Copay	Maximum Calendar Year Benefit
$15	$1,500 per member

Important information about your plan

These benefits are offered as an additional option to your medical plan. To view your plan details, register and log in at www.myProvidence.com.

- With this benefit you have access to in-network qualified practitioners, including chiropractors and acupuncturists, for chiropractic manipulations and acupuncture.
- For most plans, your medical plan deductible does not apply to these benefits, and copayment or coinsurance does not apply to your medical plan out-of-pocket maximum.
- For Health Savings Account (HSA) plans, your deductible applies to these benefits. The deductible, copayment, or coinsurance accumulated toward these services do not apply to your plan out-of-pocket maximum and the annual limit on cost sharing.
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

About your chiropractic and acupuncture benefits

This plan covers chiropractic manipulations and acupuncture when they are:

- Received from an in-network qualified practitioner, including licensed chiropractic physicians or acupuncturists, who is practicing within the scope of his or her license;
- Not listed as an exclusion in your Member Handbook.

What you need to know before you use this benefit

- While you don't need a physician's referral to receive these benefits, you must see a Providence Health Plan in-network provider. To find an in-network provider in your area, go to http://phppd.providence.org or call us.
- A copay is required per provider, per date of service. Unless you are enrolled in an HSA plan, you do not need to meet any applicable medical plan deductibles before receiving this benefit.
- Routine preventive care in the absence of an illness, injury, or disease is not covered.

Chiropractic manipulation covered services

- Manipulation of the spine, and re-evaluation as necessary.

Acupuncture covered services

- Acupuncture

Your guide to the words or phrases used to explain your benefits

Copay
The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

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 services from in-network providers.

Maximum calendar year benefit
The total dollar amount of benefits that you can receive, per calendar year.

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Your Benefit Summary

Prescription Drug Plan

Formulary B

Pacific Northwest Consulting Engineers Health & Welfare Trust

PROVIDENCE Health Plan

Important information about your plan

This summary provides only highlights of your pharmacy benefits. Certain limitations and exclusions apply. To view all your plan details, register and log in at www.myProvidence.com.

- To find out how a drug is covered under your plan, view the complete formulary and pharmacy information available online at www.ProvidenceHealthPlan.com or call us.
- You have broad access to our network of participating pharmacies and their services at discounted rates. Pharmacies are designated as participating retail, preferred retail, specialty or mail-order pharmacies.
- View a list of participating pharmacies, including specialty pharmacies, at www.ProvidenceHealthPlan.com or call us.
- Not sure what a word or phrase means? See the back for the definitions used in this summary.
- Copayments and coinsurance apply to your medical plan out-of-pocket maximum.

	Copay or Coinsurance		
Drug Coverage Category	All Participating and Preferred Retail Pharmacies (for up to a 30-day supply)	All Mail Order and Preferred Retail Pharmacies (for up to a 90-day supply of maintenance prescriptions)	All Participating Specialty Pharmacies (for up to a 30-day supply of specialty drugs)
1 - Preferred generic drug	$15	$30	N/A
2 - Non-preferred generic drug	$20	$40	
3 - Preferred brand-name drug	$25	$50	
4 - Non-preferred brand-name drug	$55	$110	
5 - Specialty drugs	N/A	N/A	50% up to $200

What you need to know about drug coverage categories

- Both generic and brand-name drugs are covered subject to the terms of your plan.
- 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.
- ACA Preventive Drugs are covered in full for up to a 30-day supply purchased at a participating / preferred retail pharmacy. Covered in full for up to a 90-day supply of maintenance drugs at a preferred retail or mail order pharmacy.
- If the cost of your prescription is less than your copay, you will only be charged the cost of the prescription.
- If your brand-name benefit includes a copayment or a coinsurance and 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 brand-name drug copayment or coinsurance indicated on the benefit summary. Your total cost, however, will never exceed the actual cost of the drug.
- Compounded medications are prescriptions that are custom prepared by your pharmacist. They may be obtained at your participating pharmacy and 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% coinsurance. Claims are subject to clinical review for medical necessity and are not guaranteed for payment.
- Specialty drugs are prescriptions that require special delivery, handling, administration and monitoring by your pharmacist and are limited to 30 days. In rare circumstances, specialty medications may be filled for a great than 30-day supply; in these cases, additional specialty cost-share(s) may apply.
- Self-administered chemotherapy drugs are covered under your pharmacy benefits or your medical benefits, whichever allows for your lowest out-of-pocket cost.
- Approved non-formulary medications will be covered at the non-preferred brand-name drug tier. Approved non-formulary specialty drugs will be covered at the specialty cost sharing tier.

Using your prescription drug benefit

- Your prescription drug benefit requires that you fill your prescriptions at a participating pharmacy.
- Be sure you present your current Providence Health Plan member identification card, along with your copay or coinsurance when you use a participating pharmacy.
- You may be assessed multiple copayments for a multi-use or unit-of-use container or package depending on the medication and the number of days supplied.
- You may purchase up to a 90-day supply of maintenance drugs using preferred retail or mail order pharmacy after the initial 30-day supply purchase. Not all drugs are considered maintenance prescriptions, including compounded drugs and drugs obtained from specialty pharmacies.
- Most specialty and chemotherapy drugs are only available at our designated specialty pharmacies. For more information, visit us online at www.ProvidenceHealthPlan.com.
- Diabetes supplies may be obtained at your participating pharmacy, and are subject to your group's medical supplies and devices benefits, limitations, and coinsurance. See your Member Handbook for details.
- Certain drugs, devices and supplies obtained from your pharmacy may apply toward your medical benefit.
- 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 your medical benefit.

Using your prescription drug formulary

- The Providence formulary is a list of FDA-approved prescription brand-name and generic drugs developed by physicians and pharmacists. It is designed to offer drug treatment choices for covered medical conditions.
- The formulary can help you and your physician choose effective medications that are less costly and minimize your out-of-pocket expense.
- Some prescription drugs require prior authorization or a formulary exception in order to be covered; these may include select formulary agents, non-formulary agents, step therapy, and/or quantity limits as listed in our Prescription Drug Formulary available on our website.
- Effective generic drug choices are available to treat most medical conditions. Visit www.ProvidenceHealthPlan.com for answers to frequently asked questions about both generic drugs and the formulary.

Ordering prescriptions by mail

- 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.
- To find participating mail-order pharmacy information visit us online at www.ProvidenceHealthPlan.com.

If you use a non-participating pharmacy

- Urgent or emergency medical situations may require that you use a non-participating pharmacy.
- If this occurs, you will need to pay full price for your prescription at the time of purchase. Reimbursement forms are available online.
- Reimbursement is subject to your plan's limitations and exclusions.

Your guide to the words or phrases used to explain your benefits

ACA Preventive drug
Affordable Care Act (ACA) preventive drugs are medications, including contraceptives, that are listed in our formulary. They 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 will not be covered in full without a written prescription from your Qualified Practitioner under your ACA preventive drug benefit.

Coinsurance
The percentage of the cost that you pay to a participating pharmacy, at the time of purchase, for a covered prescription drug.

Copay
The fixed dollar amount you pay to a participating pharmacy, at the time of purchase, for a covered prescription drug.

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

Maintenance drug
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 a month's supply 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.

Non-Formulary
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 be covered at either the highest non-specialty or specialty cost sharing tier.

Preferred brand-name drug / Non-preferred brand-name drug
Brand name drugs are protected by U.S. patent laws and only a single manufacturer has the rights to produce and sell them. Your benefits include drugs listed on our formulary as Non-preferred brand-name or Preferred brand-name drugs. Generally your out-of-pocket costs will be less for Preferred brand-name drugs.

Preferred generic drug / Non-preferred generic drug
Generic drugs have the same active-ingredient formula as the brand-name drug. Generic drugs are usually available after the brand-name patent expires. Your benefits include drugs listed on our formulary as Non-preferred generic or Preferred generic drugs. Generally your out-of-pocket costs will be less for Preferred generic drugs.

Participating pharmacies
Pharmacies that have a signed contract with Providence Health Plan to provide medications and other services at special rates. There are four types of participating pharmacies:

- Retail: a participating pharmacy that allows up to a 30-day supply 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.

For a complete description of the types of services provided by participating pharmacies, see your Member Handbook.

Prior authorization
The process used to request an exception to the Providence Health Plan drug formulary. This process can be initiated by the prescriber of the medication or the member. 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 www.ProvidenceHealthPlan.com

Self-administered chemotherapy
Oral, topical or self-injectable medications that are used to stop or slow the growth of cancerous cells.

Contact us

Headquartered in Portland, our customer service professionals have been proudly serving our members since 1986.

Portland Metro Area: 503-574-7500
All other areas: 800-878-4445
TTY: 503-574-8702 or 888-244-6642

Have questions about your benefits and want to contact us via e-mail? Go to our Web site at:
www.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
    - Information written 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://www.hhs.gov/ocr/office/file/index.html*.

Language Access Information

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: 711 :TTY).

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 می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم
می باشد. با (TTY: 711) 1-800-878-4445 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)