Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Providence Health Plan: Oregon Standard Silver - Signature Network

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, ProvidenceHealthPlan.com. For 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 www.healthcare.gov/sbc-glossary or call 1-800-878-4445 to request a copy.

### Important Questions

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td><strong>In-Network:</strong> $3,650 person / $7,300 family (2 or more).</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. Most preventive care in-network.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td><strong>In-Network:</strong> $6,800 person / $13,600 family (2 or more).</td>
<td>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.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums, balance billing, penalties, services not covered, fees above UCR.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td><strong>Will you pay less if you use a network provider?</strong></td>
<td>Yes. See ProvidenceHealthPlan.com/findaprovider or call 1-800-878-4445 for a list of network providers.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Do you need a referral to see a specialist?</strong></td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$40 <strong>copay</strong>/per visit; <strong>deductible</strong> does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$70 <strong>copay</strong>/per visit; <strong>deductible</strong> does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/ immunization</td>
<td>No charge; <strong>deductible</strong> does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have a test</td>
<td><strong>Diagnostic test</strong> (x-ray, blood work)</td>
<td>30% <strong>coinsurance</strong></td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>30% <strong>coinsurance</strong></td>
<td>Not covered</td>
</tr>
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<td>-------------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Network Provider (You will pay the least)</strong></td>
<td><strong>Out-of-Network Provider (You will pay the most)</strong></td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Tier 1 drugs</td>
<td>$15 copay / per 30 day supply retail; deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Tier 2 drugs</td>
<td>$15 copay / per 30 day supply retail; deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Tier 3 drugs</td>
<td>$55 copay / per 30 day supply retail; deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Tier 4 drugs</td>
<td>50% coinsurance retail; deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Tier 5 drugs</td>
<td>50% coinsurance retail; deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Tier 6 drugs</td>
<td>50% coinsurance retail; deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care</td>
<td>30% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>30% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$70 copay / per visit; deductible does not apply in-network</td>
<td>$70 copay / per visit</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

For more information about limitations and exceptions, see plan or policy document at [ProvidenceHealthPlan.com](http://ProvidenceHealthPlan.com)
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<tbody>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td></td>
<td></td>
<td>All services except provider office visits must be prior authorized. See your benefit summary for ABA services.</td>
</tr>
<tr>
<td></td>
<td>Outpatient services</td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Office visit: $40 copay per visit; deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All other services: 30% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge; deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
### Common Medical Event: Home health care
- **Services You May Need**
  - Home health care
- **What You Will Pay**
  - Network Provider (You will pay the least): 30% coinsurance
  - Out-of-Network Provider (You will pay the most): Not covered
- **Limitations, Exceptions, & Other Important Information**
  - **Prior authorization** required.

### Common Medical Event: Rehabilitation services
- **Services You May Need**
  - Rehabilitation services
- **What You Will Pay**
  - Inpatient: 30% coinsurance
  - Outpatient - Physical Therapy: $40 copay/per visit; deductible does not apply
  - Outpatient - Occupational & Speech Therapy: $40 copay/per visit; deductible does not apply
  - Network Provider (You will pay the least): Not covered
  - Out-of-Network Provider (You will pay the most): Not covered
- **Limitations, Exceptions, & Other Important Information**
  - Inpatient services: Limited to 30 days for in-network providers per calendar year. Limited to 60 days for in-network providers per calendar year for head/spinal injuries. **Prior authorization** required. Outpatient services: Limited to 30 visits for in-network providers per calendar year. Additional visits per specified condition: Limited to 30 visits for in-network providers per calendar year. Limits do not apply to Mental Health Services.

### Common Medical Event: Habilitation services
- **Services You May Need**
  - Habilitation services
- **What You Will Pay**
  - Inpatient: 30% coinsurance
  - Outpatient: $40 copay/per visit; deductible does not apply
  - Network Provider (You will pay the least): Not covered
  - Out-of-Network Provider (You will pay the most): Not covered
- **Limitations, Exceptions, & Other Important Information**
  - Inpatient services: Limited to 30 days for in-network providers per calendar year. Limited to 60 days for in-network providers per calendar year for head/spinal injuries. **Prior authorization** required. Outpatient services: Limited to 30 visits for in-network providers per calendar year. Limits do not apply to Mental Health Services.

### Common Medical Event: Skilled nursing care
- **Services You May Need**
  - Skilled nursing care
- **What You Will Pay**
  - Network Provider (You will pay the least): 30% coinsurance
  - Out-of-Network Provider (You will pay the most): Not covered
- **Limitations, Exceptions, & Other Important Information**
  - **Prior authorization** required. Limited to 60 days for in-network providers per calendar year.

### Common Medical Event: Durable medical equipment
- **Services You May Need**
  - Durable medical equipment
- **What You Will Pay**
  - Diabetic Supplies: No charge; deductible does not apply
  - All other equipment: 30% coinsurance
  - Network Provider (You will pay the least): Not covered
  - Out-of-Network Provider (You will pay the most): Not covered
- **Limitations, Exceptions, & Other Important Information**
  - None

### Common Medical Event: Hospice services
- **Services You May Need**
  - Hospice services
- **What You Will Pay**
  - Network Provider (You will pay the least): 30% coinsurance
  - Out-of-Network Provider (You will pay the most): Not covered
- **Limitations, Exceptions, & Other Important Information**
  - **Prior authorization** required. Respite care: Limited to 5 days, up to 30 days per lifetime for in-network providers.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>No charge; deductible does not apply</td>
<td>Not covered</td>
<td>Limited to 1 exam per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>No charge; deductible does not apply</td>
<td>Not covered</td>
<td>Limited to 1 pair per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>None</td>
</tr>
</tbody>
</table>

**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.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery (with certain exceptions)
- Dental care (Adult)
- Dental care (Child)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (covered for diabetics)
- Voluntary termination of pregnancy
- Weight loss programs

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

- Hearing aids (limits apply)
- Non-emergency care when traveling outside the U.S. See ProvidenceHealthPlan.com

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:
- Oregon Division of Financial Regulation at 1-888-877-4894, email DFR.InsuranceHelp@oregon.gov or go to https://drf.oregon.gov/help/Pages/index.aspx, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or http://www.cciio.cms.gov. 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 www.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 on how 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: Providence Health Plan at 1-800-878-4445, the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa, or you can contact the Oregon Division of Financial Regulation by:
- Calling 503-947-7984 or the toll free message line at 888-877-4894
- Writing to the Oregon Division of Financial Regulation, Consumer Protection Unit at P.O. Box 14480 Salem, OR 97309-0405

For more information about limitations and exceptions, see plan or policy document at ProvidenceHealthPlan.com
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 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, kwiijigo holne’ 1-800-887-4445 (TTY: 711).

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately one minute per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0123.
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)**

<table>
<thead>
<tr>
<th><strong>Cost-Sharing</strong></th>
<th><strong>Total Example Cost</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$3,650</td>
</tr>
<tr>
<td>Specialist copayment</td>
<td>$70</td>
</tr>
<tr>
<td>Hospital (facility) coinsurance</td>
<td>30%</td>
</tr>
<tr>
<td>Other coinsurance</td>
<td>30%</td>
</tr>
</tbody>
</table>

This EXAMPLE event includes services like:
- Specialist office visits (pre-natal 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:
- **Deductibles**: $3,650
- **Copayments**: $10
- **Coinsurance**: $1,900
- **What isn't covered**: $20
- **The total Peg would pay is**: $5,580

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

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</tr>
</tbody>
</table>

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:
- **Deductibles**: $100
- **Copayments**: $1,200
- **Coinsurance**: $0
- **What isn't covered**: $0
- **The total Joe would pay is**: $1,300

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

<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$3,650</td>
</tr>
<tr>
<td>Specialist copayment</td>
<td>$70</td>
</tr>
<tr>
<td>Hospital (facility) coinsurance</td>
<td>30%</td>
</tr>
<tr>
<td>Other coinsurance</td>
<td>30%</td>
</tr>
</tbody>
</table>

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:
- **Deductibles**: $2,100
- **Copayments**: $300
- **Coinsurance**: $0
- **What isn't covered**: $0
- **The total Mia would pay is**: $2,400

*Note: This plan has other deductibles for specific services included in this coverage example. See “Are there other deductibles for specific services?” row above.

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

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 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.

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。

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VIETNAMESE: Nếu bạn nói Tiếng Việt, có dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-878-4445 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

ПОМНИТЕ: Якщо ви говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-878-4445 (телетайп: 711).

XIYYEFFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-878-4445 (TTY: 711).


ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-878-4445 (ATS : 711).

提要：如果使用簡體中文，您可用免費語言援助服務。請撥打 1-800-878-4445 (TTY: 711)。