



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, visit ump.regence.com/sebb or call 1 (800) 628-3481 (TRS: 711). 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) 628-3481 (TRS: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	\$125 individual / \$375 family per calendar 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 <u>deductible</u>?	Yes. Certain <u>preventive care</u> and those services listed below as " <u>deductible</u> does not apply".	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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	\$2,000 individual / \$4,000 family per calendar year. <u>Prescription drugs</u> : \$2,000 individual / \$4,000 family per calendar 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 <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> charges, member <u>coinsurance</u> paid to <u>out-of-network providers</u> and non- <u>network</u> pharmacies, and health care this <u>plan</u> doesn't cover. <u>Prescription drugs</u> do not apply to the medical <u>out-of-pocket limit</u> and are subject to their own <u>out-of-pocket limit</u> .	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 <u>network provider</u>?	Yes. Find a doctor at ump.regence.com/go/sebb/ump-plus-pshvn or call 1- 800-628-3481 (TRS: 711) for a list of <u>network providers</u> (preferred providers). For a list of network pharmacies, visit the <u>pharmacy-locator webpage</u> at https://ump.regence.com/go/pharmacy-locator or call 1-888-361-1611 (TRS: 711).	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 <u>referral</u> to see a <u>specialist</u>?	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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	No charge, <u>deductible</u> does not apply; All other services: 15% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Primary care provider</u> must be contracted with UMP Plus–PSHVN to avoid being billed as <u>out-of-network</u> .
	<u>Specialist</u> visit	15% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Specialist</u> must be contracted with UMP Plus–PSHVN to be covered as <u>in-network</u> .
	<u>Preventive care/screening/immunization</u>	No charge, <u>deductible</u> does not apply	50% <u>coinsurance</u> , <u>deductible</u> does not apply	<u>Coinsurance</u> and <u>deductible</u> do not apply for childhood immunizations from <u>out-of-network providers</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.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	15% <u>coinsurance</u>	50% <u>coinsurance</u>	Certain tests aren't covered, and other tests require <u>preauthorization</u> . Please refer to your <u>plan</u> document. *See section Radiology
	Imaging (CT/PET scans, MRIs)	15% <u>coinsurance</u>	50% <u>coinsurance</u>	

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 drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at ump.regence.com/sebb/benefits/prescriptions	Value Tier (Specific high value <u>prescription drugs</u> used to treat certain chronic conditions)	5% <u>coinsurance</u> or \$10 <u>copay</u> , whichever is less / prescription	5% <u>coinsurance</u>	* <u>Coinsurance</u> for certain Tier 2 and covered <u>specialty drugs</u> (see Preferred Drug List), are capped at \$35 per 30-day supply. <u>Preauthorization</u> may be required. Please refer to your <u>plan</u> document. *See section Your prescription drug benefit. Up to a 90-day supply / retail prescription (your <u>cost share</u> is per 30-day supply) 90-day supply / mail-order prescription Postal Prescription Services (PPS) and Costco Mail Order Pharmacy are the <u>plan's</u> only <u>network</u> mail-order pharmacies. <u>Specialty drugs</u> must be filled from the specialty pharmacy, Ardon Health, except when a drug can only be dispensed by a certain pharmacy. Covers up to a 30-day supply for most specialty <u>prescription drugs</u> . <u>Prescription drugs</u> filled at excluded pharmacies are not covered.
	Tier 1 (Low-cost generic <u>prescription drugs</u>)	10% <u>coinsurance</u> or \$25 <u>copay</u> , whichever is less / prescription	10% <u>coinsurance</u>	
	Tier 2 (Preferred brand drugs and high-cost generic drugs)	30% <u>coinsurance</u> or \$75 <u>copay</u> , whichever is less, up to 30 day supply / prescription*	30% <u>coinsurance</u>	
	<u>Specialty drugs</u>	Refer to Value Tier, Tier 1, and Tier 2 drugs above.	Refer to Value Tier, Tier 1, and Tier 2 drugs above.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Physician/surgeon fees	15% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required. *See section Surgery.
If you need immediate medical attention	<u>Emergency room care</u>	15% <u>coinsurance</u> after \$75 <u>copay</u> / visit	15% <u>coinsurance</u> after \$75 <u>copay</u> / visit	<u>Copayment</u> applies to facility charge for each visit (waived if admitted), whether or not the <u>deductible</u> has been met.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Coverage is not provided for air or water ambulance if ground ambulance would serve the same purpose. Ambulance services for personal or convenience purposes are not covered.
	<u>Urgent care</u>	15% <u>coinsurance</u>	50% <u>coinsurance</u>	None

* For more information about limitations and exceptions, see the plan or policy document at hca.wa.gov/ump-sebb-coc.

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 have a hospital stay	Facility fee (e.g., hospital room)	\$200 <u>copay</u> per day up to \$600 per individual per calendar year	50% <u>coinsurance</u>	<u>Provider</u> must notify <u>plan</u> on admission.
	Physician/surgeon fees	15% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required. *See section Surgery.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required. *See section Behavioral health.
	Inpatient services	\$200 <u>copay</u> per day up to \$600 per individual per calendar year Professional services: No charge	50% <u>coinsurance</u>	<u>Preauthorization</u> required for inpatient admissions. <u>Provider</u> must notify the <u>plan</u> for detoxification, intensive outpatient program, and partial <u>hospitalization</u> . *See section Behavioral health.
If you are pregnant	Office visits	15% <u>coinsurance</u>	50% <u>coinsurance</u>	<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 described elsewhere in the SBC (i.e. ultrasound). *See section Therapy: Habilitative and rehabilitative.
	Childbirth/delivery professional services	15% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$200 <u>copay</u> per day up to \$600 per individual per calendar year	50% <u>coinsurance</u>	

* For more information about limitations and exceptions, see the plan or policy document at hca.wa.gov/ump-sebb-coc.

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	<u>Home health care</u>	15% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Rehabilitation services</u>	Inpatient: \$200 <u>copay</u> per day up to \$600 per individual per calendar year Professional services: 15% <u>coinsurance</u> Outpatient services: 15% <u>coinsurance</u>	50% <u>coinsurance</u>	60 inpatient days / year 60 outpatient visits / year (combined with <u>habilitation services</u>) Professional and outpatient services are covered at the <u>coinsurance</u> specified, after <u>deductible</u> . Includes physical therapy, occupational therapy and speech therapy. Inpatient admissions for <u>rehabilitation services</u> must be <u>preauthorized</u> . *See section Therapy: Habilitative and rehabilitative.
	<u>Habilitation services</u>	15% <u>coinsurance</u>	50% <u>coinsurance</u>	60 professional neurodevelopmental visits / year (combined with outpatient <u>rehabilitation services</u>) Includes physical therapy, occupational therapy and speech therapy. <u>Preauthorization</u> is required. *See section Therapy: Habilitative and rehabilitative.
	<u>Skilled nursing care</u>	Inpatient: \$200 <u>copay</u> per day up to \$600 per individual per calendar year Professional services: 15% <u>coinsurance</u>	50% <u>coinsurance</u>	150 inpatient days / year <u>Preauthorization</u> is required. *See section Skilled nursing facility.
	<u>Durable medical equipment</u>	15% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Hospice services</u>	No charge	50% <u>coinsurance</u>	Hospice care / 6 months 14 respite inpatient or outpatient days / lifetime
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

* For more information about limitations and exceptions, see the plan or policy document at hca.wa.gov/ump-sebb-coc.

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.)

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|---|-------------------------|------------------------|
| • Cosmetic surgery, except congenital anomalies | • Infertility treatment | • Private-duty nursing |
| • Dental care | • Long-term care | • Routine eye care |
| | | • Weight loss programs |

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

- | | | |
|---|--|---------------------|
| • Acupuncture, 24 visits / year | • Hearing aids, \$3,000 per ear / 36 months | • Routine foot care |
| • Bariatric surgery | • Non-emergency care when traveling outside the U.S. | |
| • Chiropractic care, 24 spinal manipulations / year | | |

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 ccio.cms.gov or your state insurance department. You may also contact the [plan](#) at 1 (800) 628-3481 (TRS: 711). 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) 628-3481 (TRS: 711) 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 Office of the Insurance Commissioner of Washington State by calling 1 (800) 562-6900, or through the Internet at: www.insurance.wa.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 (866) 240-9580.

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 <u>plan's</u> overall <u>deductible</u>	\$125
■ <u>Specialist</u> <u>coinsurance</u>	15%
■ Hospital (facility) <u>copayment</u>	\$200
■ Other <u>coinsurance</u>	15%

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:

Cost Sharing	
<u>Deductibles</u>	\$125
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$800
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$1,185

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$125
■ <u>Specialist</u> <u>coinsurance</u>	15%
■ Hospital (facility) <u>copayment</u>	\$200
■ Other <u>coinsurance</u>	15%

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:

Cost Sharing	
<u>Deductibles</u>	\$125
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,100
What isn't covered	
Limits or exclusions	\$200
The total Joe would pay is	\$1,425

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$125
■ <u>Specialist</u> <u>coinsurance</u>	15%
■ Hospital (facility) <u>copayment</u>	\$200
■ Other <u>coinsurance</u>	15%

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:

Cost Sharing	
<u>Deductibles</u>	\$125
<u>Copayments</u>	\$80
<u>Coinsurance</u>	\$400
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$605

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

NONDISCRIMINATION NOTICE

Regence complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity. Regence does not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation or gender identity.

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, sex, sexual orientation or gender identity, 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>

You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal available at <https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status>, or by phone at 800-562-6900, 360-586-0241 (TDD).

Complaint forms are available at
<https://fortress.wa.gov/oic/online services/cc/pub/complaintinformation.aspx>

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' hódíilnih 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)

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፤ የሚከተለው 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)

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