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://asuris.com] **(Applies to custom groups)** [https://asuris.com/go/2023/booklet/EW/HSAHealthplan3.051-100] **(Applies to standard groups 51-100)** [https://asuris.com/go/2023/booklet/EW/HSAHealthplan3.0101+] **(Applies to standard groups 101+)** or call 1 [(888) 367-2109.] **(FI)** [(866) 240-9580.] **(ASO)** 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) 367-2109] **(FI)** [(866) 240-9580] **(ASO)** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	[${1,500 – 6,200} individual (single coverage) / ${**Two times the individual amount**} family{*} **(See * below)** per calendar year.] **(Applies for non-embedded combined deductible option)** [$3,000 individual (single coverage) / ${5,000 / 7,000} family per calendar year.] **(Applies for embedded combined deductible option)** [In-network: ${1,500 / 2,500 / 3,500 / 4,500 / 5,000} individual (single coverage) / ${**Two times the individual amount**} family{*} **(Applies for non-embedded, see * below)** per calendar year. Out-of-network: ${3,000 / 5,000 / 10,000} individual (single coverage) / ${**Two times the individual amount**} family per calendar year.] **(Applies when deductible amounts are separate)** [*An individual on family coverage will not have their {in-network} deductible exceed ${3,000 – 7,000}.] **(Applies for non-embedded deductible option when In-Network family deductible amount exceeds the individual on family OOPM amount.)**	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.] **(Applies to embedded deductible option or non-embedded when the individual deductible amount is the same as the individual OOP limit amount)** [If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.] **(Applies to non-embedded deductible option when the individual deductible amount and individual OOP limit amount is not the same)**

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?	[${3,000 – 6,200} individual (single coverage) / ${**Two times the individual amount**} family* per calendar year. *An individual on family coverage will not have their out-of-pocket limit exceed ${3,000 – 6,200} **(Matches single coverage OOP)**.] **(Applies when OOP amounts are combined)** [In-network: ${4,500 / 5,000 / 7,000} individual (single coverage) / ${9,000 / 10,000 / 14,000} family* per calendar year. Out-of-network: ${6,000 / 10,000 / 15,000} individual (single coverage) / ${12,000 / 20,000 / 30,000} family per calendar year. *An individual on family coverage will not have their in-network out-of-pocket limit exceed ${4,500 / 5,000 / 7,000} **(If customized, must match single coverage OOP)**.] **(Applies when the OOP amounts are separate; if there is no limit on out-of network OOP, enter "Not Applicable.")**	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?	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://asuris.com/go/EW/Preferred or call 1 [(888) 367-2109] **(FI)** [(866) 240-9580] **(ASO)** 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	[0 / 20]% coinsurance	[0 / 40 / 50]% coinsurance	None
	Specialist visit	[0 / 20]% coinsurance	[0 / 40 / 50]% coinsurance	
	Preventive care/screening/ immunization	No charge	[0 / 40 / 50]% coinsurance	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)	[0 / 20]% coinsurance	[0 / 40 / 50]% coinsurance	None
	Imaging (CT/PET scans, MRIs)	[0 / 20]% coinsurance	[0 / 40 / 50]% coinsurance	
[**If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at https://asuris.com/go/2023/EW/3tier	Tier 1	{0 / 20}% coinsurance / retail prescription {0 / 20}% coinsurance / home delivery prescription		Prescription drugs not on the Drug List are not covered, unless an exception is approved. {Deductible does not apply for insulin.} **(Group declines OVML)** {Deductible does not apply for insulin and drugs specifically designated as preventive for treatment of certain chronic diseases that are on the Optimum Value Medication List.} **(Group chooses OVML)** 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). Coverage includes compound medications at {0 / 50}% coinsurance. [Cost shares for insulin will not exceed $35 / 30-day supply retail prescription or $105 / 90-day supply home delivery (mail order) prescription.] **(Does not apply to HSA 100 plans)**
	Tier 2	{0 / 20}% coinsurance / retail prescription {0 / 20}% coinsurance / home delivery prescription		
	Tier 3	{0 / 20}% coinsurance / retail prescription {0 / 20}% coinsurance / home delivery prescription		
	Specialty drugs	Refer to tier 2 and tier 3 drugs above.		

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)	
				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 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.] **(3-Tier Rx)**
[If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://asuris.com/go/2023/EW/6tierLG	Tier 1	{0 / 20}% coinsurance / retail prescription {0 / 20}% coinsurance / home delivery prescription		Prescription drugs not on the Drug List are not covered, unless an exception is approved. {Deductible does not apply for insulin.} **(Group declines OVML)** {Deductible does not apply for insulin and drugs specifically designated as preventive for treatment of certain chronic diseases that are on the Optimum Value Medication List.} **(Group chooses OVML)** 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). Coverage includes compound medications at {0 / 50}% coinsurance. [Cost shares for insulin will not exceed $35 / 30-day supply retail prescription or $105 / 90-day supply home delivery (mail order) prescription.] **(Does not apply to HSA 100 plans)** 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 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
	Tier 2	{0 / 20}% coinsurance / retail prescription {0 / 20}% coinsurance / home delivery prescription		
	Tier 3	{0 / 20}% coinsurance / retail prescription {0 / 20}% coinsurance / home delivery prescription		
	Tier 4	{0 / 20}% coinsurance / retail prescription {0 / 20}% coinsurance / home delivery prescription		
	Tier 5	{0 / 20}% coinsurance / specialty drug		
	Tier 6	{0 / 50}% coinsurance / specialty drug		

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)	
				retail pharmacy; additional refills must be provided by a specialty pharmacy.] **(6-Tier Rx)**
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	[10% coinsurance for ambulatory surgery centers; 20% coinsurance for all other facilities] **(Applies when there is an ASC differential)** [{0 / 20}% coinsurance] **(Applies when there is no ASC differential or coins is 0%)**	[0 / 40 / 50]% coinsurance	None
	Physician/surgeon fees	[10% coinsurance for ambulatory surgery center physicians; 20% coinsurance for all other physicians] **(Applies when there is an ASC differential)** [{0 / 20}% coinsurance] **(Applies when there is no ASC differential or coins is 0%)**	[0 / 40 / 50]% coinsurance	None
If you need immediate medical attention	Emergency room care	[0 / 20]% coinsurance	[0 / 20 / 50]% coinsurance	[None] **(Applies when deductibles are combined)** [In-network deductible applies to in-network and out-of-network services.] **(Applies when deductibles are separate)**
	Emergency medical transportation	[0 / 20]% coinsurance	[0 / 20 / 50]% coinsurance	[None] **(Applies when deductibles are combined)** [In-network deductible applies to in-network and out-of-network services.] **(Applies when deductibles are**

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)	
				separate)
	Urgent care	Covered the same as **If you visit a health care provider's office or clinic** (Primary care visit or Specialist visit) or **If you have a test** above.		None
If you have a hospital stay	Facility fee (e.g., hospital room)	[0 / 20]% coinsurance	[0 / 40 / 50]% coinsurance	None
	Physician/surgeon fees	[0 / 20]% coinsurance	[0 / 40 / 50]% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	[0 / 20]% coinsurance	[0 / 40 / 50]% coinsurance	None
	Inpatient services	[0 / 20]% coinsurance	[0 / 40 / 50]% coinsurance	None
If you are pregnant	Office visits	[0 / 20]% coinsurance	[0 / 40 / 50]% coinsurance	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	[0 / 20]% coinsurance	[0 / 40 / 50]% coinsurance	
	Childbirth/delivery facility services	[0 / 20]% coinsurance	[0 / 40 / 50]% coinsurance	
If you need help recovering or have other special health needs	Home health care	[0 / 20]% coinsurance	[0 / 40 / 50]% coinsurance	130 visits / year
	Rehabilitation services	[0 / 20]% coinsurance	[0 / 40 / 50]% coinsurance	30 inpatient days / year 25 outpatient visits / year Includes physical therapy, occupational therapy and speech therapy.
	Habilitation services	[0 / 20]% coinsurance	[0 / 40 / 50]% coinsurance	25 professional neurodevelopmental visits / year Includes physical therapy, occupational therapy and speech therapy.
	Skilled nursing care	[0 / 20]% coinsurance	[0 / 40 / 50]% coinsurance	60 inpatient days / year
	Durable medical equipment	[0 / 20]% coinsurance	[0 / 40 / 50]% coinsurance	None
	Hospice services	[0 / 20]% coinsurance	[0 / 40 / 50]% coinsurance	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

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] **(Default: Always excluded unless an ASO group chooses this optional benefit)**
- Cosmetic surgery, except congenital anomalies
- Dental care (Adult)
- Hearing aids
- [Infertility treatment] **(Applies when optional infertility benefit is not selected)**
- Long-term care
- 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
- Acupuncture
- [Bariatric surgery] **(ASO Only: Applies when optional bariatric surgery benefit is selected)**
- Chiropractic care
- [Infertility treatment] **(Applies when optional infertility benefit is selected)**
- Non-emergency care when traveling outside the U.S.

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) 367-2109.] **(FI)** [(866) 240-9580.] **(ASO)** 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) 367-2109] **(FI)** [(866) 240-9580] **(ASO)** or visit asuris.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 [(888) 367-2109.] **(FI)** [(866) 240-9580.] **(ASO)**

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** **$[]**
- **Specialist coinsurance** **[]%**
- **Hospital (facility) coinsurance** **[]%**
- **Other coinsurance** **[]%**

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	$[]
Copayments	$[]
Coinsurance	$[]
What isn't covered	
Limits or exclusions	$[]
The total Peg would pay is	**$[]**

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

- **The plan's overall deductible** **$[]**
- **Specialist coinsurance** **[]%**
- **Hospital (facility) coinsurance** **[]%**
- **Other coinsurance** **[]%**

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	$[]
Copayments	$[]
Coinsurance	$[]
What isn't covered	
Limits or exclusions	$[]
The total Joe would pay is	**$[]**

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

- **The plan's overall deductible** **$[]**
- **Specialist coinsurance** **[]%**
- **Hospital (facility) coinsurance** **[]%**
- **Other coinsurance** **[]%**

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	$[]
Copayments	$[]
Coinsurance	$[]
What isn't covered	
Limits or exclusions	$[]
The total Mia would pay is	**$[]**

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

NONDISCRIMINATION NOTICE

Asuris 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, gender identity or sexual identity. Asuris does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity or sexual orientation.

Asuris:
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
1-888-232-8229 (TTY: 711)

If you believe that Asuris has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity or sexual orientation, 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@asuris.com

Customer Service for all other plans
Civil Rights Coordinator
MS CS B32B, P.O. Box 1271
Portland, OR 97207-1271
1-888-232-8229 (TTY: 711)
CS@Asuris.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.

- 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/onlineservices/cc/pub/complaintinformation.aspx

Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-232-8229 (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 1-888-232-8229 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-232-8229 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-232-8229 (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 1-888-232-8229 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-232-8229 (телетайп: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-232-8229 (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。1-888-232-8229（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 1-888-232-8229 (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 1-888-232-8229 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-232-8229 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-232-8229 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-232-8229 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-888-232-8229 (TTY: 711)

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፤ በሚከተለው ቁጥር ይደውሉ 1-888-232-8229 (መስማት ለተሳናቸው:- 711)።

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-232-8229 (телетайп: 711)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-232-8229 (टिटिवाइ: 711

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-232-8229 (TTY: 711)

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-232-8229 (TTY: 711)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-232-8229 (TTY: 711)

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