



Regence MedAdvantage + Rx Enhanced Plus Opt 1 (PPO)

# 2026 Medicare Retiree Group Summary of Benefits

January 1, 2026 – December 31, 2026

for the Association of Washington Cities (AWC)

For more information

Visit our website at [regence.com/mrg](https://www.regence.com/mrg).

Prospective members call **1-888-279-1346** (TTY: 711) 8 a.m. to 5 p.m., Monday through Friday.

Contact Customer Service at **1-888-319-8904** (TTY: 711). Customer Service hours are 8 a.m. to 8 p.m., Monday through Friday (October 1 through March 31, our telephone hours are from 8 a.m. to 8 p.m., seven days a week).

This document is available electronically and may be available in other formats.

## **What you need to know about this book**

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the Evidence of Coverage (EOC).

## **Who can join?**

To join a Regence Medicare Advantage Retiree Group Plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, be eligible for your employer's retiree plan and live within the United States. As long as you are eligible for your employer's retiree plan, you will have coverage in any state you live in (excluding U.S. territories).

## **Tips for comparing your Medicare benefits**

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or use the Medicare Plan Finder on [www.medicare.gov](http://www.medicare.gov).
- If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at [www.medicare.gov](http://www.medicare.gov) or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

## **Which doctors, hospitals, and pharmacies can I use?**

Regence participates in the Blue Medicare Advantage PPO Network Sharing Program. If you use a Regence MedAdvantage PPO network provider, or any other provider who participates in the PPO Network Sharing Program, you will receive in-network benefits for covered services. If you reside in a county or state that does not participate in the Blue Medicare Advantage PPO Network Program, you will still receive in-network benefits for covered services as long as your chosen provider accepts Medicare. If you choose to use an out-of-network provider when an in-network provider is available, you may pay more for your services, except in urgent and emergency situations.

Go to our website at [regence.com/mrg](http://regence.com/mrg) to search for a network provider or pharmacy using the online directories. You can also view the plan Drug List (Formulary) to see what drugs are covered and if there are any restrictions.

When reviewing the following charts, you'll see the cost differences for in-network vs. out-of-network care and services. You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

## Regence MedAdvantage + Rx Enhanced Plus Opt 1

| Plan costs & limits                                                                                                                                                                                                                                                                                                  |                                                                              |                         |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|-------------------------|
| <b>Annual deductible</b>                                                                                                                                                                                                                                                                                             | \$0                                                                          |                         |
| <b>Maximum out-of-pocket responsibility</b><br>Annual limit on your out-of-pocket costs for your Medicare-covered services. This amount does not include prescription drugs.<br><br>If you reach the limit on out-of-pocket costs, we will pay the full cost for Medicare-covered services for the rest of the year. | \$0 for services you receive from in- and out-of-network providers combined. |                         |
| Medical benefits                                                                                                                                                                                                                                                                                                     | In-network                                                                   | Out-of-network          |
| <b>Inpatient hospital coverage<sup>1</sup></b><br>Our plan covers an unlimited number of days per stay                                                                                                                                                                                                               | \$0 per day: days 1-999                                                      | \$0 per day: days 1-999 |
| <b>Outpatient hospital services</b>                                                                                                                                                                                                                                                                                  |                                                                              |                         |
| Wound care services                                                                                                                                                                                                                                                                                                  | \$0                                                                          | \$0                     |
| All other services <sup>1</sup>                                                                                                                                                                                                                                                                                      | \$0                                                                          | \$0                     |
| Observation services                                                                                                                                                                                                                                                                                                 | \$0                                                                          | \$0                     |
| <b>Ambulatory surgery center services</b>                                                                                                                                                                                                                                                                            |                                                                              |                         |
| Wound care services                                                                                                                                                                                                                                                                                                  | \$0                                                                          | \$0                     |
| All other services <sup>1</sup>                                                                                                                                                                                                                                                                                      | \$0                                                                          | \$0                     |
| <b>Doctor visits</b>                                                                                                                                                                                                                                                                                                 |                                                                              |                         |
| Primary care provider                                                                                                                                                                                                                                                                                                | \$0                                                                          | \$0                     |
| Virtual primary care provider visits                                                                                                                                                                                                                                                                                 | \$0                                                                          | \$0                     |
| Specialist                                                                                                                                                                                                                                                                                                           | \$0                                                                          | \$0                     |
| Virtual specialist visits                                                                                                                                                                                                                                                                                            | \$0                                                                          | \$0                     |
| <b>Preventive care</b>                                                                                                                                                                                                                                                                                               |                                                                              |                         |
| Medicare-covered services:<br>Abdominal aortic aneurysm screening<br>Alcohol misuse screening and counseling<br>Annual wellness visit<br>Bone mass measurement<br>Breast cancer screening (mammogram)<br>Cardiovascular disease risk reduction visit<br>Cardiovascular disease testing                               | \$0                                                                          | \$0                     |

*1- Services may require prior authorization. 2- Services do not apply to the out-of-pocket maximum.*

| Medical benefits                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | In-network | Out-of-network |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|----------------|
| Cervical and vaginal cancer screening<br>Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)<br>Depression screenings<br>Diabetes screenings<br>HIV screening<br>Lung cancer with low dose computed tomography (LDCT) screening<br>Medical nutrition therapy<br>Obesity screenings and counseling<br>Prostate cancer screenings (PSA)<br>Sexually transmitted infections screenings and counseling<br>Tobacco use cessation counseling<br>Vaccines (flu, pneumonia, COVID-19, Hepatitis B)<br>Welcome to Medicare visit (one-time) |            |                |
| Annual routine physical exam                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | \$0        | \$0            |
| <b>Emergency care</b><br>Your copay is waived if admitted to the hospital within 48 hours.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |            |                |
| Emergency room visit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | \$0        | \$0            |
| Worldwide emergency care                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | \$0        | \$0            |
| <b>Urgently needed services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |            |                |
| Urgent care visit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | \$0        | \$0            |
| Virtual urgent care visits - through your local care center                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | \$0        | \$0            |
| Virtual urgent care visits - through our virtual care provider Doctor On Demand                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | \$0        | Not covered    |
| Worldwide urgent care visit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | \$0        | \$0            |
| <b>Diagnostic services/labs/imaging</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |            |                |
| HbA1C testing                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | \$0        | \$0            |
| Lab services <sup>1</sup>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | \$0        | \$0            |
| Outpatient x-rays                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | \$0        | \$0            |
| Diagnostic tests and procedures <sup>1</sup>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | \$0        | \$0            |
| Diagnostic mammography                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | \$0        | \$0            |

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| Medical benefits                                                                                    | In-network                     | Out-of-network          |
|-----------------------------------------------------------------------------------------------------|--------------------------------|-------------------------|
| Diagnostic radiology (MRI, CT, etc.) <sup>1</sup>                                                   | \$0                            | \$0                     |
| <b>Hearing services</b>                                                                             |                                |                         |
| Exam to diagnose and treat hearing and balance issues                                               | \$0                            | \$0                     |
| Routine hearing exam <sup>2</sup> - 1 per calendar year, in-network services provided by TruHearing | \$0                            | \$150                   |
| Hearing aids <sup>2</sup> - 1 per ear per calendar year, aids must be provided by TruHearing        | \$499, \$699, or \$999 per aid | Not covered             |
| <b>Dental services</b>                                                                              |                                |                         |
| Medicare-covered services                                                                           | \$0                            | \$0                     |
| <b>Vision services</b>                                                                              |                                |                         |
| Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening) | \$0                            | \$0                     |
| Routine eye exam <sup>2</sup> - 1 per calendar year, in-network services provided by VSP            | \$0                            | 50%                     |
| Routine eyewear <sup>2</sup> - in-network services provided by VSP                                  |                                |                         |
| Lenses - standard basic single-vision, lined bifocal, lined trifocal or lenticular are covered      | \$0                            | 50%                     |
| Frames or contacts - allowance for in- or out-of-network every calendar year                        | \$200                          | \$200                   |
| <b>Mental health services</b>                                                                       |                                |                         |
| Inpatient psychiatric hospital <sup>1</sup> - 190-day lifetime maximum                              | \$0 per day: days 1-190        | \$0 per day: days 1-190 |
| Outpatient mental health <sup>1</sup> - individual or group                                         | \$0                            | \$0                     |
| Virtual mental health visits - through your provider                                                | \$0                            | \$0                     |
| Virtual mental health visits - through our virtual care provider Doctor On Demand                   | \$0                            | Not covered             |
| <b>Skilled nursing facility<sup>1</sup></b><br>Up to 100 days covered per benefit period            | \$0 per day: days 1-100        | \$0 per day: days 1-100 |
| <b>Outpatient rehabilitation services<sup>1</sup></b>                                               |                                |                         |
| Occupational therapy                                                                                | \$0                            | \$0                     |
| Physical and speech language therapy                                                                | \$0                            | \$0                     |
| Virtual outpatient rehabilitation                                                                   | \$0                            | \$0                     |

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| Medical benefits                                                                                                        | In-network  | Out-of-network |
|-------------------------------------------------------------------------------------------------------------------------|-------------|----------------|
| <b>Ambulance</b>                                                                                                        |             |                |
| Copay per each one-way Medicare-covered transport                                                                       |             |                |
| Ground ambulance                                                                                                        | \$0         | \$0            |
| Air ambulance <sup>1</sup>                                                                                              | \$0         | \$0            |
| Worldwide ground or air ambulance <sup>1</sup>                                                                          | \$0         | \$0            |
| <b>Transportation</b>                                                                                                   | Not covered | Not covered    |
| <b>Medicare Part B drugs<sup>1</sup></b>                                                                                |             |                |
| Chemotherapy drugs                                                                                                      | \$0         | \$0            |
| Other Part B drugs                                                                                                      | \$0         | \$0            |
| Part B insulin                                                                                                          | \$0         | \$0            |
| <b>Acupuncture</b>                                                                                                      |             |                |
| Medicare-covered services only - limited to treatment of chronic low back pain                                          | \$0         | \$0            |
| Additional non-Medicare-covered services <sup>2</sup> -                                                                 | \$0         | \$0            |
| <b>Chiropractic</b>                                                                                                     |             |                |
| Medicare-covered services only - limited to manipulation of the spine to correct a subluxation                          | \$0         | \$0            |
| Additional non-Medicare-covered services <sup>2</sup> -                                                                 | \$0         | \$0            |
| <b>Massage therapy<sup>2</sup></b>                                                                                      | \$0         | \$0            |
| 6 visits per calendar year, up to 60 minutes per visit                                                                  |             |                |
| <b>Naturopathy<sup>2</sup></b>                                                                                          | \$0         | \$0            |
| <b>Diabetic services</b>                                                                                                |             |                |
| Diabetic monitoring supplies - in-network supplies limited to Ascensia Contour or Abbott FreeStyle at a retail pharmacy | \$0         | \$0            |
| Continuous glucose monitor (CGM) and supplies - in-network limited to Dexcom or Abbott FreeStyle Libre                  | \$0         | \$0            |
| Diabetes self-management training                                                                                       | \$0         | \$0            |
| Lancets, lancet devices, therapeutic shoes, and inserts                                                                 | \$0         | \$0            |
| Diabetic routine footcare <sup>2</sup> - 6 visits per calendar year                                                     | \$0         | \$0            |
| Medicare diabetes prevention program (MDPP)                                                                             | \$0         | \$0            |

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| Medical benefits                                                                        | In-network | Out-of-network |
|-----------------------------------------------------------------------------------------|------------|----------------|
| <b>Fitness program<sup>2</sup></b><br>Fitness membership through the Silver&Fit program | \$0        | Not covered    |
| <b>Home health agency care<sup>1</sup></b>                                              | \$0        | \$0            |
| <b>Medical equipment and supplies<sup>1</sup></b>                                       |            |                |
| Durable medical equipment                                                               | \$0        | \$0            |
| Prosthetics and medical supplies                                                        | \$0        | \$0            |
| <b>Outpatient substance use disorder services<sup>1</sup></b><br>Individual or group    | \$0        | \$0            |

*1- Services may require prior authorization. 2- Services do not apply to the out-of-pocket maximum.*

## Prescription drugs

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you.

You may pay more than your copay or coinsurance amount if you get drugs from an out-of-network pharmacy. Long-term care facility residents pay the same as at a standard retail pharmacy and are limited to a 31-day supply.

**Annual prescription (Part D) deductible stage**                      \$0

**Initial coverage stage** (the amount you pay until you have paid \$2,100 for covered drugs)

|                                       | 30-day | up to 100-day |
|---------------------------------------|--------|---------------|
| <b>Tier 1: Preferred generic</b>      |        |               |
| Standard retail / Standard mail order | \$0    | \$0           |
| <b>Tier 2: Generic</b>                |        |               |
| Standard retail / Standard mail order | \$0    | \$0           |
| <b>Tier 3: Preferred brand</b>        |        |               |
| Standard retail / Standard mail order | \$0    | \$0           |
| <b>Tier 4: Non-preferred drug</b>     |        |               |
| Standard retail / Standard mail order | \$0    | \$0           |
| <b>Tier 5: Specialty</b>              |        |               |
| Standard retail / Standard mail order | \$0    | N/A           |

### Catastrophic coverage stage

After your yearly out-of-pocket drug costs reach \$2,100, you pay nothing.

### Part D vaccine

Our plan covers most adult Part D vaccines at no cost to you.

## Pre-enrollment checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1-888-319-8904**.

### Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Call **1-888-319-8904** to request a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

### Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Your current health care coverage will end once your new Medicare coverage starts. For example, if you are in Tricare or a Medicare plan, you will no longer receive benefits from that plan once your new coverage starts.
- ☐ Benefits, premiums and/or copayments/ coinsurance may change on January 1, 2027.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.

## Disclaimers

Regence BlueShield serves select counties in the state of Washington and is an Independent Licensee of the Blue Cross and Blue Shield Association.

Regence is an HMO/PPO/PDP plan with a Medicare contract. Enrollment in Regence depends on contract renewal.

Out-of-network/noncontracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our Customer Service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

You can submit a marketing complaint to us by calling the phone number on the back of your member ID card or by calling 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048, 24 hours a day/ 7 days a week. Please reference your agent's name if applicable.

Utilization Management (UM) is the way we review the type and amount of care you're getting. This involves looking at the setting for your care and its medical necessity. Clinical professionals make decisions based on our clinical review criteria, guidelines, and medical policies. Examples of UM procedures include pre-service review (prior authorization), concurrent review (including urgent concurrent review) and post-service review. Find more information in our Member FAQ on **[regence.com/medicare/resources/faq](https://www.regence.com/medicare/resources/faq)**.

The Silver&Fit® program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). Silver&Fit is a registered trademark of ASH and used with permission herein. Other names may be trademarks of their respective owners.

Doctor On Demand is a separate company that provides telehealth services. Silver&Fit is a separate company that provides wellness and health information services. TruHearing is a separate company that provides discounted hearing products. VSP is a separate company that provides vision 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 ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់បម្រើអ្នក។ 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)

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

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

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

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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.

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