



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, contact Moda Health at www.modahealth.com or by calling 1-866-923-0409. 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 www.healthcare.gov/sbc-glossary or call 1-888-217-2363 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers \$700 coordinated care individual / \$800 non-coordinated care individual / \$1,600 family; for out-of-network providers \$1,100 individual / \$2,200 family.	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 .
Are there services covered before you meet your deductible?	Yes. Examples of some services: For coordinated care members, in-network primary care visits, office visits, urgent care visit, acupuncture, spinal manipulation, naturopathic substances and biofeedback are covered before you meet your deductible . For all members, in-network breastfeeding support, chemical dependency services, outpatient mental health office visits, tobacco cessation treatment, virtual care visits, and most preventive care as well as in and out of network prescription medication and breastfeeding supplies are covered before you meet your deductible .	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 https://www.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?	For network providers \$3,750 coordinated care individual / \$4,150 non-coordinated care individual / \$8,300 family; for out-of-network providers \$6,900 individual / \$13,800 family.	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, transplants and bariatric surgery not performed at Center of Excellence facilities, out-of-pocket expenses in excess of the reference price for an oral appliance or hip and knee replacements, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider ?	Yes. See www.modahealth.com or call 1-866-923-0409 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
		Network Provider		Out-of-Network Provider (You will pay the most)	
		Coordinated Care (You will pay the least)	Non-Coordinated Care		
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 copay /visit, no deductible for PCP 360 and \$45 copay /visit, no deductible for other providers \$15 copay /visit, no deductible for virtual care visits	20% coinsurance \$15 copay /visit, no deductible for virtual care visits	50% coinsurance	No charge for virtual care visit with CirrusMD.
	Specialist visit	\$25 copay /visit, no deductible for acupuncture and spinal manipulation; \$45 copay /visit, no deductible for other visits.	20% coinsurance	50% coinsurance	No charge for virtual care visit with CirrusMD. Includes office visits by chiropractors, naturopathic physicians and acupuncturists. Limited to 12 visits per plan year for acupuncture care and spinal manipulation.
	Preventive care/screening /immunization	No charge for most services. \$25 copay /visit or 20% coinsurance for remaining services. No deductible for most services.	No charge for most services. 20% coinsurance for remaining services.	50% coinsurance	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider		Out-of-Network Provider (You will pay the most)	
		Coordinated Care (You will pay the least)	Non-Coordinated Care		
If you have a test	Diagnostic test (x-ray, blood work)	No charge for services at Quest Labs. 20% coinsurance for other providers.	No charge for services at Quest Labs. 20% coinsurance for other providers.	50% coinsurance	Includes other tests such as EKG, allergy testing and sleep study. Some services require a \$100 copay .
	Imaging (CT/PET scans, MRIs)	\$100 copay , then 20% coinsurance	\$100 copay , then 20% coinsurance	\$100 copay , then 50% coinsurance	Prior authorization is required for many services. Failure to obtain prior authorization results in denial
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.modahealth.com/pdl	Value tier	\$4 copay /retail, \$8 copay /mail-order, and \$12 copay /90-day retail prescription	\$4 copay /retail, \$8 copay /mail-order, and \$12 copay /90-day retail prescription	\$4 copay /retail prescription	No deductible . Covers up to a 31-day supply (retail pharmacy); and 90-day supply (mail order and participating retail pharmacies). Prior authorization may be required. Mail order at Moda designated mail order pharmacy only.
	Select tier	\$12 copay /retail, \$24 copay /mail-order, and \$36 copay /90-day retail prescription	\$12 copay /retail, \$24 copay /mail-order, and \$36 copay /90-day retail prescription	\$12 copay /retail prescription	Covers up to a 31-day supply for most specialty medications. Prior authorization may be required. Moda designated pharmacy only.
	Preferred tier	25% coinsurance : up to \$75 maximum retail; up to \$150 maximum mail-order; and up to \$225 maximum 90-day retail prescription	25% coinsurance : up to \$75 maximum retail; up to \$150 maximum mail-order, and up to \$225 maximum 90-day retail prescription	25% coinsurance , up to \$75 maximum retail prescription	High-cost non-preferred medications are excluded unless a formulary exception is requested and approved.
	Nonpreferred tier	50% coinsurance : up to \$175 maximum retail; up to \$450 maximum mail-order; and up to \$525 maximum 90-day retail prescription	50% coinsurance : up to \$175 maximum retail; up to \$450 maximum mail-order; and up to \$525 maximum 90-day retail prescription	50% coinsurance , up to \$175 maximum retail prescription	Anticancer medication is covered at no charge for in-network providers. \$35 maximum for 31-day supply and \$105 maximum for 90-day supply for insulin, deductible does not apply.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information	
		Network Provider		Out-of-Network Provider (You will pay the most)		
		Coordinated Care (You will pay the least)	Non-Coordinated Care			
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.modahealth.com/pdl	Specialty tier	\$12 copay for 31-day supply, or \$36 for 90-day supply when allowed, for generic prescription, 25% coinsurance up to \$200 maximum for 31-day supply, or \$400 for 90-day supply when allowed, for preferred prescription, 50% coinsurance up to \$500 maximum for 31-day supply, or \$1,000 for 90-day supply when allowed, for non-preferred prescription	\$12 copay for 31-day supply, or \$36 for 90-day supply when allowed, for generic prescription, 25% coinsurance up to \$200 maximum for 31-day supply, or \$400 for 90-day supply when allowed, for preferred prescription, 50% coinsurance up to \$500 maximum for 31-day supply, or \$1,000 for 90-day supply when allowed, for non-preferred prescription	Not covered		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	20% coinsurance	50% coinsurance	Prior authorization may be required. Failure to obtain prior authorization results in denial.	
	Physician/surgeon fees	20% coinsurance	20% coinsurance	50% coinsurance		
If you need immediate medical attention	Emergency room care	\$100 copay /visit, then 20% coinsurance	\$100 copay /visit, then 20% coinsurance	\$100 copay /visit, then 20% coinsurance	Copay waived if hospital admission immediately follows. In-network deductible and out-of-pocket limit applies.	
	Emergency medical transportation	20% coinsurance	20% coinsurance	20% coinsurance	In-network deductible and out-of-pocket limit apply.	
	Urgent care	\$45 copay /visit, no deductible	20% coinsurance	20% coinsurance	20% coinsurance	In-network deductible and out-of-pocket limit applies to mental health and chemical dependency services.
		\$15 copay /visit, no deductible for virtual care visits	\$15 copay /visit, no deductible for virtual care visits			No charge for virtual care visit with CirrusMD.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider		Out-of-Network Provider (You will pay the most)	
		Coordinated Care (You will pay the least)	Non-Coordinated Care		
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance	50% coinsurance	Prior authorization is required. Failure to obtain prior authorization results in denial.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 copay , no deductible for office visits and substance abuse services. \$15 copay /visit, no deductible for virtual care visits. 20% coinsurance for other services.	\$25 copay , no deductible for office visits and substance abuse services. \$15 copay /visit, no deductible for virtual care visits. 20% coinsurance for other services.	50% coinsurance	No charge for virtual care visit with CirrusMD. Prior authorization is required for some services. Failure to obtain prior authorization results in denial.
	Inpatient services	\$25 copay , no deductible for some substance abuse services. 20% coinsurance for other services.	\$25 copay , no deductible for some substance abuse services. 20% coinsurance for other services.	50% coinsurance	Prior authorization is required. Failure to obtain prior authorization results in denial.
If you are pregnant	Office visits	20% coinsurance	20% coinsurance	50% coinsurance	Cost sharing does not apply to certain preventive services . Depending on the type of services, a copay , coinsurance , or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	20% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider		Out-of-Network Provider (You will pay the most)	
		Coordinated Care (You will pay the least)	Non-Coordinated Care		
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	50% coinsurance	Plan year maximum of 140 visits.
	Rehabilitation services	20% coinsurance	20% coinsurance	50% coinsurance	Plan year maximum of 30 days for inpatient and 30 sessions for outpatient rehabilitation except as required for mental health parity. May be eligible for 60 days for inpatient and 60 sessions for outpatient rehabilitation for acute head or spinal cord injury. Habilitation services are limited to services that qualify under rehabilitation guidelines and medically necessary to treat a mental health condition. Prior authorization may be required. Failure to obtain prior authorization results in denial.
	Habilitation services	20% coinsurance	20% coinsurance	50% coinsurance	
	Skilled nursing care	20% coinsurance	20% coinsurance	50% coinsurance	Plan year maximum of 60 days
	Durable medical equipment	20% coinsurance	20% coinsurance	50% coinsurance	Includes supplies and prosthetics. Frequency limits apply to some DME. Prior authorization may be required. Failure to obtain prior authorization results in denial.
	Hospice services	20% coinsurance	20% coinsurance	50% coinsurance	None.
If your child needs dental or eye care	Children’s eye exam	No charge	No charge	Not covered	Limited to in-network preventive vision screening for children age 3-5. Eye exams are not covered for other ages.
	Children’s glasses	Not covered	Not covered	Not covered	None
	Children’s dental check-up	Not covered	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 .)		
• Cosmetic Surgery, except as required for certain situations • Dental Care (Adult) except for accident related injuries	• Long Term Care • Private Duty Nursing	• Routine Eye Care (Adult) • Routine Foot Care, except for diabetes • Weight Loss Programs, except for WW
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Abortion • Acupuncture • Bariatric Surgery	• Chiropractic Care • Hearing Aids	• Infertility Treatment • Naturopathic supplies • 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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or <http://www.dol.gov/ebsa/healthreform> for group health coverage subject to ERISA, the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov for non-federal governmental group health plans, and the Oregon Division of Financial Regulation at 1-888-877-4894 or www.dfr.oregon.gov for Church plans. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information 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: Moda Health at 1-866-923-0409. For group health coverage subject to ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Oregon Division of Financial Regulation at 1-888-877-4894 or www.dfr.oregon.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 888-786-7461.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 888-873-1395.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 888-873-1395.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 888-873-1395.

—————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	\$700
■ Specialist copayment	\$45
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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	
Deductibles	\$700
Copayments	\$10
Coinsurance	\$2,400
What isn't covered	
Limits or exclusions	\$50
The total Peg would pay is	\$3,160

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$700
■ Specialist copayment	\$45
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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	
Deductibles	\$400
Copayments	\$300
Coinsurance	\$1,000
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,720

Mia's Simple Fracture

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

■ The plan's overall deductible	\$700
■ Specialist copayment	\$45
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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	
Deductibles	\$700
Copayments	\$300
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,300

Nondiscrimination notice

We follow federal civil rights laws. We do not discriminate based on race, religion, color, national origin, age, disability, gender identity, sex or sexual orientation.

We provide free services to people with disabilities so that they can communicate with us. These include sign language interpreters and other forms of communication.

If your first language is not English, we will give you free interpretation services and/or materials in other languages.

If you need any of the above, call:

888-217-2363 (TDD/TTY 711)

If you think we did not offer these services or discriminated, you can file a written complaint.

Please mail or fax it to:

Moda Partners, Inc.
Attention: Appeal Unit
601 SW Second Ave.
Portland, OR 97204
Fax: 503-412-4003

If you need help filing a complaint, please call Customer Service.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone:

U.S. Department of Health
and Human Services
200 Independence Ave. SW, Room 509F
HHH Building, Washington, DC 20201
800-368-1019, 800-537-7697 (TDD)

You can get Office for Civil Rights complaint forms at hhs.gov/ocr/office/file/index.html.

Scott White coordinates our nondiscrimination work:

Scott White,
Compliance Officer
601 SW Second Ave.
Portland, OR 97204
855-232-9111
compliance@modahealth.com

modahealth.com

Dental plans in Oregon provided by Oregon Dental Service, dba Delta Dental Plan of Oregon. Dental plans in Alaska provided by Delta Dental of Alaska. Delta Dental is a trademark of Delta Dental Plans Association. Health plans provided by Moda Health Plan, Inc. Individual medical plans in Alaska provided by Moda Assurance Company.



ATENCIÓN: Si habla español, hay disponibles servicios de ayuda con el idioma sin costo alguno para usted. Llame al 1-877-605-3229 (TTY: 711).

CHÚ Ý: Nếu bạn nói tiếng Việt, có dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Gọi 1-877-605-3229 (TTY: 711)

注意：如果您說中文，可得到免費語言幫助服務。請致電1-877-605-3229（聾啞人專用：711）

주의: 한국어로 무료 언어 지원 서비스를 이용하시려면 다음 연락처로 연락해주시기 바랍니다. 전화 1-877-605-3229 (TTY: 711)

PAUNAWA: Kung nagsasalita ka ng Tagalog, ang mga serbisyong tulong sa wika, ay walang bayad, at magagamit mo. Tumawag sa numerong 1-877-605-3229 (TTY: 711)

تنبيه: إذا كنت تتحدث العربية، فهناك خدمات مساعدة لغوية متاحة لك مجانًا. اتصل برقم (الهاتف النصي: 711) 1-877-605-3229

بولتے ہیں تو لسانی (URDU) توجہ دیں: اگر آپ اردو اعمانت آپ کے لیے بلا معاوضہ دستیاب ہے۔ پر کال کریں 1-877-605-3229 (TTY: 711)

ВНИМАНИЕ! Если Вы говорите по-русски, воспользуйтесь бесплатной языковой поддержкой. Позвоните по тел. 1-877-605-3229 (текстовый телефон: 711).

ATTENTION : si vous êtes locuteurs francophones, le service d'assistance linguistique gratuit est disponible. Appelez au 1-877-605-3229 (TTY: 711)

توجہ: در صورتی کہ بہ فارسی صحبت می کنید، خدمات ترجمہ بہ صورت رایگان برای شما موجود است. با تماس بگیرید. (TTY: 711) 1-877-605-3229

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपको भाषाई सहायता बिना कोई पैसा दिए उपलब्ध है। 1-877-605-3229 पर कॉल करें (TTY: 711)

Achtung: Falls Sie Deutsch sprechen, stehen Ihnen kostenlos Sprachassistentendienste zur Verfügung. Rufen sie 1-877-605-3229 (TTY: 711)

注意:日本語をご希望の方には、日本語サービスを無料で提供しております。1-877-605-3229 (TTY、テレタイプライターをご利用の方は711)までお電話ください。

અવલોકન: જો તમે (ભાષાંતર કરેલ ભાષા અહીં દર્શાવેલ) બોલો છો તો તે ભાષામાં તમારે માટે વિના મૂલ્યે સહાય ઉપલબ્ધ છે. 1-877-605-3229 (TTY: 711) પર કોલ કરો

ໂປດຊາບ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການຊ່ວຍເຫຼືອດ້ານພາສາແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ເສັຍຄ່າ. ໂທ 1-877-605-3229 (TTY: 711)

УВАГА! Якщо ви говорите українською, для вас доступні безкоштовні консультації рідною мовою. Зателефонуйте 1-877-605-3229 (TTY: 711)

ATENȚIE: Dacă vorbiți limba română, vă punem la dispoziție serviciul de asistență lingvistică în mod gratuit. Sunați la 1-877-605-3229 (TTY 711)

THOV CEEB TOOM: Yog hais tias koj hais lus Hmoob, muaj cov kev pab cuam txhais lus, pub dawb rau koj. Hu rau 1-877-605-3229 (TTY: 711)

ត្រូវចងចាំ: បើអ្នកនិយាយភាសាខ្មែរ ហើយ ត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដោយ ឥតគិតថ្លៃ គឺមានផ្តល់ជូនលោកអ្នក។ សូមទូរស័ព្ទ ទៅកាន់លេខ 1-877-605-3229 (TTY: 711)

HUBACHIIISA: Yoo afaan Kshtik kan dubbattan ta'e tajaajiloonni gargaarsaa isiniif jira 1-877-605-3229 (TTY: 711) tiin bilbilaa.

โปรดทราบ: หากคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี โทร 1-877-605-3229 (TTY: 711)

FA'AUTAGIA: Afai e te tautala i le gagana Samoa, o loo avanoa fesoasoani tau gagana mo oe e le totogia. Vala'au i le 1-877-605-3229 (TTY: 711)

IPANGAG: Nu agsasaoka iti llocano, sidadaan ti tulong iti lengguahe para kenka nga awan bayadna. Umawag iti 1-877-605-3229 (TTY: 711)

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwonić: 1-877-605-3229 (obsługa TTY: 711)