INDIVIDUAL AND FAMILY PLANS

GroupHealth®

2017

Compare your plan options

IMPORTANT DATES
2017 open enrollment:* Nov. 1, 2016 – Jan. 31, 2017

For coverage beginning	Deadline to enroll direct from Group Health ghc.org/if	Deadline to enroll with Washington Healthplanfinder wahealthplanfinder.org
Jan. 1, 2017	Dec. 31, 2016	Dec. 23, 2016
Feb. 1, 2017	Jan. 31, 2017	Jan. 23, 2017
March 1, 2017	Jan. 31, 2017	Jan. 31, 2017

Featuring our value-driven Core network plans

*Certain qualifying events — such as if you lose your health coverage, or have a birth or adoption in your family — allow you to enroll in a health plan or modify your coverage at any time during the year, as long as it's no more than 60 days from the date of the qualifying event.

Everything you've been looking for in a health plan is right here

Group Health offers great benefit coverage, value for your money, and choice of high-quality providers from our Core provider network.

Centered on Group Health doctors and clinics, the Core network provides you with cost-effective, high-quality, patient-satisfying care from 10,000+ providers across the state.

The Core network features:

- More than 1,000 providers at 25 Group Health Medical Centers*
- More than 9,000 contracted providers, including 49 hospitals
- Specialists in more than 60 disciplines, which makes us one of the largest multi-specialty groups in the state

To review our extensive network of specially selected providers, go to ghc.org/if.

No matter what plan you choose, you'll enjoy a whole host of services and ways to access your care. Because after you've done the hard work of finding the right plan, your plan should work hard for you.

Let's get started.

1 Check to see if you're in our area.

Check this list of counties to be sure you live where our plans are available.

Benton	Kitsap	San Juan	Walla Walla
Columbia	Kittitas	Skagit	Whatcom
Franklin	Lewis	Snohomish	Whitman
Island	Mason	Spokane	Yakima
King	Pierce	Thurston	

2 Should you purchase your plan from us or through the exchange?

All of our plans are offered direct from Group Health, and purchasing from us means you'll enjoy a simple, streamlined application process. However, many of our plans are also available on Washington Healthplanfinder, with additional plans for those who meet one or more of these requirements:

- You qualify for financial assistance.
- You're under 30 or experiencing a qualifying hardship.
- You are American Indian or Alaska Native, making you eligible for low-cost or no-cost health coverage.

Find information at ghc.org/if and enroll at wahealthplanfinder.org.

*OIC Provider Network Form A

3 Which metal tier works best when you consider your monthly budget and how much you'll pay when you access care?

Metal tiers	Monthly premium	Deductibles, coinsurance, copays
Bronze plans	$	$$$
Silver plans	$$	$$
Gold plans	$$$	$

4 Use this chart to further narrow your options.

YOU	CORE Offered direct from Group Health and/or through Washington Healthplanfinder							
	Core Basics Plus* Page 4	**Bronze** Page 4	**Flex Bronze** Page 4	**Core Bronze HSA** Page 5	**Core Silver HSA** Page 5	**VisitsPlus Silver HD** Page 5	**Flex Silver** Page 5	**Flex Gold** Page 5
Are eligible for financial assistance**		●	●	●	●	●	●	●
Want an HSA-compatible plan				●	●			
Don't expect to use a lot of health care services (lower premium, higher costs for care)	●	●	●	●				
Think your use of health care services will be moderate (balanced premium and costs for care)					●	●	●	
Expect to use a lot of health care services (higher premium, lower costs for care)								●
Want a low monthly premium and that is the most important thing	●	●	●	●				
Like the idea of a few visits ("up-front visits") before your deductible kicks in	●		●			●	●	●

*Only available through Washington Healthplanfinder to those who are under 30 or experiencing some sort of hardship.
**Only available through Washington Healthplanfinder.

Ready to apply?

You can mail in the enclosed application or enroll online at ghc.org/if, where you can also see information about our plans, dental coverage, health care reform, and even find a primary or specialty care provider. See enrollment details on the back cover.

2017 Group Health Cooperative plans:
Core Provider Network

	CORE BASICS PLUS CATASTROPHIC* For adults under 30 or experiencing some sort of hardship	BRONZE	FLEX BRONZE
CALENDAR COSTS			
Annual deductible	$7,150 Indiv / $14,300 Family	$7,150 Indiv / $14,300 Family	$7,000 Indiv / $14,000 Family
Coinsurance	0%	0%	20%
Out-of-pocket maximum	$7,150 Indiv / $14,300 Family	$7,150 Indiv / $14,300 Family	$7,150 Indiv / $14,300 Family
COMMONLY USED BENEFITS	**After deductible is met, you pay:**	**After deductible is met, you pay:**	**After deductible is met, you pay:**
Office visits Primary and specialty care Acupuncture — 12 visits PCY Manipulative therapy — 10 visits PCY Adult vision exam — 1 exam PCY	**First 3 primary visits covered in full ◆** Primary: $0 Specialty: 0%	Primary: $0 Specialty: $0	Primary: $40 **First 3 visits = ◆**, then 20% Specialty: 20%
Prescription drugs Costs per 30-day supply	Generic: 0% Brand: 0% Specialty: 0%	Generic: 0% Brand: 0% Specialty: 0%	Generic: $25 ◆ Brand: 40% Specialty: 50%
Mail order prescription drugs Costs per 30-day supply up to a 90-day supply, except specialty—Group Health mail order only	Generic: 0% Brand: 0% Specialty: 0%	Generic: 0% Brand: 0% Specialty: 0%	Generic: $20 ◆ Brand: 35% Specialty: 50%
Urgent care	$0	Primary: $0	Primary: $40 or 20%
Hospitalization	0%	0%	20%
Emergency services	0%	0%	20%
OTHER ESSENTIAL BENEFITS			
Preventive services	Covered in full ◆	Covered in full ◆	Covered in full ◆
Maternity Routine outpatient prenatal and postpartum visits Labor and delivery: Hospital inpatient / outpatient surgery	Covered in full ◆ 0%	Covered in full ◆ 0%	Covered in full ◆ 20%
Laboratory and radiology services	0%	0%	20%
Rehabilitative and habilitative services and devices Inpatient rehabilitation — 30 days PCY Outpatient rehabilitation — 25 visits PCY Durable medical equipment (including prosthetics)	0%	0%	20% 20% 20%
Ambulatory outpatient services	0%	0%	20%
Pediatric vision Covered for members under age 19 1 routine exam per year; 1 pair of lenses and frames PCY or annual supply of contacts in lieu of glasses	Covered in full ◆	Covered in full ◆	Covered in full ◆

◆ **DEDUCTIBLE DOES NOT APPLY**

*Only available through Washington Healthplanfinder

NOTE: This is an overview of benefits. The contents are not to be accepted or construed as a substitute for the provisions of the medical coverage agreement. Other terms and conditions may apply. A list of excluded services and other limitations can be found in each plan's Summary of Benefits and Coverage document.

CORE BRONZE HSA	CORE SILVER HSA	VISITSPLUS SILVER HD	FLEX SILVER	FLEX GOLD
$5,500 Indiv / $11,000 Family	$3,000 Indiv / $6,000 Family	$7,150 Indiv / $14,300 Family	$1,750 Indiv / $3,500 Family	$850 Indiv / $1,700 Family
20%	10%	0%	30%	20%
$6,550 Indiv / $13,100 Family	$5,750 Indiv / $11,500 Family	$7,150 Indiv / $14,300 Family	$6,850 Indiv / $13,700 Family	$5,000 Indiv / $10,000 Family
After deductible is met, you pay:	**After deductible is met, you pay:**	**After deductible is met, you pay:**	**After deductible is met, you pay:**	**After deductible is met, you pay:**
20%	10%	**Unlimited office visits prior to deductible** Primary: $30 ◆ Specialty: $55 ◆	**First 4 primary or specialty visits = ◆** Primary: $20 Specialty: $45	**First 5 primary or specialty visits = ◆** Primary: $10 Specialty: $30
Generic: 20% Brand: 40% Specialty: 50%	Generic: 10% Brand: 30% Specialty: 50%	Generic: $12 ◆ Brand: $55 ◆ Specialty: 50%	Generic: $10 ◆ Brand: 40% Specialty: 50%	Generic: $10 ◆ Brand: $35 ◆ Specialty: 40%
Generic: 15% Brand: 35% Specialty: 50%	Generic: 5% Brand: 25% Specialty: 50%	Generic: $7 ◆ Brand: $50 ◆ Specialty: 50%	Generic: $5 ◆ Brand: 35% Specialty: 50%	Generic: $5 ◆ Brand: $30 ◆ Specialty: 40%
20%	10%	Primary: $30 ◆	Primary: $20	Primary: $10
20%	10%	0%	30%	20%
20%	10%	0%	$200 + 30%	$200 + 20%
Covered in full ◆	Covered in full ◆	Covered in full ◆	Covered in full ◆	Covered in full ◆
Covered in full ◆ 20%	Covered in full ◆ 10%	Covered in full ◆ 0%	Covered in full ◆ 30%	Covered in full ◆ 20%
20%	10%	0%	30%	20%
20%	10%	0% Specialty: $55 ◆ 0%	30% Specialty: $45 30%	20% Specialty: $30 20%
20%	10%	0%	30%	20%
Covered in full ◆	Covered in full ◆	Covered in full ◆	Covered in full ◆	Covered in full ◆

Dental coverage is required for those under age 19. See page 6 for details about available dental plans and how to make sure you have the required pediatric dental coverage, if applicable.

◆ **DEDUCTIBLE DOES NOT APPLY**

PCY = per calendar year

2017 Adult/family and pediatric Dental coverage

Oral health is an important part of your overall health. When you select a Group Health medical plan, you can choose to add this vital dental coverage — for yourself, for your children, or for your entire family.

These Delta Dental plans give you the freedom to see any dentist, and you receive better benefits when you see a Delta Dental participating dentist. Take a look at the summary of benefits on this page.

GET DENTAL COVERAGE FOR YOU AND YOUR FAMILY

We work with Delta Dental of Washington to offer you dental coverage when paired with one of our 2017 medical plans.

A federal mandate requires dental coverage for anyone younger than 19. You can buy this coverage separately or with a family dental plan.

Adult/family plan

The optional adult/family plan includes dental coverage for those younger and older than 19.

- This plan is available for adults and families who purchase their medical plan directly from Group Health.
- Adults or families who purchase their medical plan through Washington Healthplanfinder can also purchase their family dental there.

For details, see the Adult/Family Plan summary of benefits on page 7.

Pediatric-only plan

The pediatric-only plan includes dental coverage for those younger than 19 only.

- This plan is available if you purchase your medical plan directly from Group Health.
- If you purchase your medical plan through Washington Healthplanfinder you will be required to purchase pediatric dental for those under age 19 through Washington Healthplanfinder.

For details, see the Pediatric-Only Plan summary of benefits on page 7.

FIND A DENTIST IN OUR NETWORK

You may choose a dentist from two networks: Delta Dental PPO or Delta Dental Premier. To find a participating, in-network dentist in your area, visit deltadentalwa.com and use the Find a Dentist tool.

Why choose a Delta Dental PPO or Premier dentist

Delta Dental network dentists provide treatments at discounted rates and file all claims paperwork for you. Delta Dental will pay its portion and you're only responsible for your stated deductibles, coinsurance, and any amounts in excess of the plan maximums.

In most cases, your out-of-pocket savings will be the greatest if you choose a dentist from the Delta Dental PPO network.

When you visit an in-network dentist, be sure to mention that you're covered by Delta Dental of Washington. Give them your member identification number, plan name, and group number.

Out-of-network vs in-network dentists

You are not limited to using a Delta Dental network dentist. You may use any licensed dentist.

If you choose a non-participating (out-of-network) dentist, you are responsible for having the dentist complete your claim forms and for ensuring the claims are submitted to Delta Dental.

Claim payments to out-of-network dentists are based on actual charges or Delta Dental's maximum allowable fees for non-participating dentists, whichever is less. You're then responsible for any balance remaining after Delta Dental pays. Unlike participating dentists, Delta Dental has no control over non-participating dentists' charges or billing procedures.

Questions

Call Delta Dental customer service at 1-800-554-1907 or visit deltadentalwa.com.

Summary of benefits

	ADULT / FAMILY PLAN				PEDIATRIC-ONLY PLAN	
	Pediatric (under age 19)		Adult (age 19 and older)		Only for those under age 19	
	Delta Dental participating dentist*	Non-participating dentist	Delta Dental participating dentist*	Non-participating dentist	Delta Dental participating dentist*	Non-participating dentist
Annual maximum	Unlimited		$1,250 $1,000 annual TMJ maximum $5,000 lifetime TMJ maximum		Unlimited	
Annual deductible Waived on diagnostic and preventive benefits	$85 / child		$50 / adult		$85 / child	
Out-of-pocket maximum	$350 / child $700 / family**	Not applicable	Not applicable		$350 / child $700 / family**	Not applicable
Diagnostic and preventive Exams, prophylaxis, flouride, X-rays, sealants	100%	100%	100%	100%	100%	100%
Restorative Restorations (includes posterior composites†), endodontics, periodontics, oral surgery‡	50%	50%	50%	50%	50%	50%
Major Crowns‡, dentures, partials, bridges, implants and TMJ for adults over age 19	50%	50%	50%	50%	50%	50%
Orthodontia‡ (medically necessary) Coinsurance Lifetime maximum	50% Unlimited		Not covered		50% Unlimited	

RATES	ADULT / FAMILY PLAN	PEDIATRIC-ONLY PLAN	
Individual	$42.67	This plan bills only for the first three under age 19.	
Individual + spouse	$85.36	**1 individual (<19)**	$36.55
Individual + child(ren)	$94.91	**2 individuals (<19)**	$73.10
Individual + family	$150.91	**3+ individuals (<19)**	$109.65

TMJ = temporomandibular joint
* Includes dental providers in the Delta Dental PPO℠ and Delta Dental Premier® networks
** For families with two or more children
† Covered for members under 19
‡ Requires preauthorization

This is a brief summary of benefits and does not constitute a contract.
For complete plan information, please refer to your Delta Dental of Washington benefits booklet. Group Health refers to Group Health Cooperative.

DELTA DENTAL®

Delta Dental of Washington

Definitions and details

COINSURANCE
The percentage amount you pay for the cost of the care you receive. You'll notice that the coinsurance levels differ among all of the plans.

COPAYMENT, COPAY
The set dollar amount you pay when you receive certain covered services.

DEDUCTIBLE
What you'll pay each calendar year before your full coverage kicks in. Once a family member meets their individual deductible, services are covered for that person without the entire family deductible being met. Other family members continue to pay toward the family deductible amount. For certain services, the deductible does not apply.

HSA
A health savings account (HSA) is a personal savings account that's used to pay for eligible medical expenses. You can open an HSA with your own financial institution and the money you deposit in the account is not taxed; you own and control that money. Additionally, our HSA plans feature embedded deductibles, which means that if your plan covers more than one person, full coverage kicks in for each person when they meet the individual deductible (as opposed to having to wait for the full family deductible to be met).

OUT-OF-POCKET MAXIMUM
The most you'll be required to pay for covered services in a calendar year. Deductible, coinsurance, and copays count toward this limit.

TEN ESSENTIAL BENEFITS
As part of health care reform, all health plans — regardless of provider — must include these ten essential health benefits: Ambulatory patient services • Emergency care • Hospitalization • Maternity and newborn care • Mental health and substance abuse disorder services, including behavioral health treatment • Prescription drugs • Rehabilitative and habilitative services and devices • Laboratory services • Preventive and wellness services • Pediatric services, including dental and vision care.

For details, visit ghc.org/if-resources.

PREMIUM
The fee you pay each month for your health coverage, regardless of how much or how little you access care.

UPFRONT VISITS
Our non-HSA plans offer 3, 4, 5, or unlimited office visits not subject to the deductible. It's important to note that all in-network preventive care is covered in full, not subject to the deductible, and does not count as one of your upfront visits.

VIRTUAL CARE
Now covered with no cost sharing by members. Virtual care means diagnosis and treatment of a condition through a phone call, secure message, or online diagnosis and treatment tool. HSA plans are subject to deductible per IRS rules.

PRIMARY CARE (LOWER COPAY)
These types of care are considered primary care:

Acupuncture • Chemical Dependency/Substance Abuse • Chiropractic/Manipulative Therapy • Emergency Medicine (where ER copay doesn't apply) • Family Medicine • Family Planning • General Practice • Internal Medicine • Mental Health • Midwifery • Naturopathy • Obstetrics/Gynecology • Optometry • Osteopathy • Pediatrics • Urgent Care • Women's Health Care

SPECIALTY CARE (HIGHER COPAY)
These types of care are considered specialty care:

Allergy and Immunology • Anesthesiology • Audiology • Cardiology (pediatric and cardiovascular disease) • Critical Care Medicine • Dentistry • Dermatology • Endocrinology • Enterostomal Therapy • Gastroenterology • Genetics • Hematology • Hepatology • Infectious Disease • Massage Therapy • Neonatal-Perinatal Medicine • Nephrology • Neurology • Nutrition* • Occupational Medicine • Occupational Therapy • Oncology • Ophthalmology • Orthopedics • Otolaryngology (ear, nose, and throat) • Pain Management • Pathology • Physiatry (rehabilitation) • Physical Therapy • Podiatry • Pulmonary Medicine/Disease • Radiology (nuclear medicine, radiation therapy) • Respiratory Therapy • Rheumatology • Speech Therapy • Sports Medicine • General Surgery (all surgical specialties) • Urology

* Nutrition counseling may be covered as preventive when certain requirements are met.

READY TO APPLY?

- To enroll directly with Group Health, visit **ghc.org/if** or mail in the enclosed application.
- Contact your producer (agent/broker).
- If you qualify for financial assistance, are under 30 or experiencing some kind of hardship, or are an American Indian or Alaska Native, it's to your advantage to enroll in our plans through **wahealthplanfinder.org**.
- You can also call us at **206-448-4141** or **1-800-358-8815**. If you're hearing- or speech-impaired, call the Washington state TTY Relay number at **1-800-833-6388** or **711**.

GroupHealth®

IF0001213-09-16 2016-08

Group Health Nondiscrimination Notice and Language Access Services

GROUP HEALTH NONDISCRIMINATION NOTICE

Group Health Cooperative and Group Health Options, Inc. ("Group Health") comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Group Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Group Health:

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, 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, contact the Group Health Civil Rights Coordinator.

If you believe that Group Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
Group Health Civil Rights Coordinator, Group Health Headquarters, 320 Westlake Ave. N., Suite 100, GHQ-E2N, Seattle, WA 98109, 206-448-5819, 206-877-0645 (Fax), complianceoffice@ghc.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Group Health Civil Rights Coordinator is available to help you. 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, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

---

LANGUAGE ACCESS SERVICES

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-888-901-4636 (TTY: 1-800-833-6388 or 711).

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

中文 **(Chinese)**：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 1-888-901-4636 (TTY：1-800-833-6388 / 711）。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-901-4636 (TTY：1-800-833-6388 / 711）.

한국어**(Korean):** 주의： 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-901-4636 (TTY: 1-800-833-6388 / 711) 번으로 전화해 주십시오.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-901-4636 (телетайп: 1-800-833-6388 / 711).

Y0033_H5050_XB0001444-02-16
2017-XB-2_ACA_Notice_Taglines
Accepted 08-21-2016

Filipino (Tagalog): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Українська (Ukrainian): УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-901-4636 (телетайп: 1-800-833-6388 / 711).

ភាសាខ្មែរ (Khmer)**៖ ប្រយ័ត្ន៖** ប្រើសិនអ្នកនិយាខែរ, សេជំនួយែផក យេមិនគិតល គឺចនសំប់បំអេអក។ ចូរទូ រស័ព1-888-901-4636 (TTY: 1-800-833-6388 / 711។

日本語(Japanese): 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。1-888-901-4636（TTY:1-800-833-6388 / 711）まで、お電話にてご連絡ください。

አማርኛ (Amharic)፥ ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-901-4636 (መስማት ለተሳናቸው: 1-800-833-6388 / 711).

Oromiffa (Oromo): XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

العربية (Arabic): لديكم حق الحصول على مساعدة ومعلومات في ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-901-4636 (رقم هاتف الصم والبكم: 1-800-833-6388 / 711).

ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-901-4636 (TTY: 1-800-833-6388 / 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

ພາສາລາວ (Lao): ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Srpsko-hrvatski (Serbo-Croatian): OBAVJEŠTENJE Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-901-4636 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-833-6388 / 711).

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-901-4636 (ATS : 1-800-833-6388 / 711).

Română (Romanian): ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Adamawa (Fulfulde): MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

فارسی (Farsi): توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-901-4636 (TTY: 1-800-833-6388 / 711) تماس بگیرید.