GlobalHealth

2017 Schedule of Benefits

State, Education & Local Government Employees

HIOS Plan ID - 85408OK0060005
GlobalHealth Plan ID - MSTSB17

MG-SB-17

GlobalHealth, Inc.
701 NE 10th Street, Suite 300
Oklahoma City, OK 73104-5403
www.globalhealth.com/state

HELPFUL NUMBERS

Plan Issuer:
GlobalHealth, Inc.
PO Box 2393
Oklahoma City, OK 73101-2393
www.globalhealth.com/state

GlobalHealth Customer Care, Language Assistance, and Disease Management:
CommercialAnswers@globalhealth.com
405.280.5600
1.877.280.5600 (toll-free)
711 (TTY)
Mon – Fri, 9 am – 5 pm

24/7 Nurse Help Line:
Information Line
1.877.280.2993 (toll-free)

GlobalHealth Compliance Officer:
405.280.5852
1.877.280.5852 (toll-free)
compliance@globalhealth.com

GlobalHealth Privacy Officer:
405.280.5524
privacy@globalhealth.com

Behavioral Health:
CommercialAnswers@globalhealth.com
405.280.5600
1.877.280.5600 (toll-free)
711 (TTY)
Mon – Fri, 9 am – 5 pm

Pharmacy Benefits Manager:
Express Scripts Holding Company
1.866.274.1612 (toll-free)
1.800.899.2114 (TTY)

Medication Prior Authorizations:
gh.pharmacy@globalhealth.com
918.878.7361

Mail Claims to:
Express Scripts
Attn: Commercial Claims
PO Box 14711
Lexington, KY 40512-4711

Mail Order Pharmacy:
Express Scripts Customer Service Center
1.866.274.1612 (toll-free)
1.800.899.2114 (TTY)
24 hours/7 days a week
www.express-scripts.com

***Specialty Pharmacy:**
Accredo Specialty Pharmacy
1.888.608.9010
www.accredo.com

*Accredo Specialty Pharmacy is not the exclusive Specialty Drug Pharmacy. You have the option to use other pharmacies.

Table of Contents

IMPORTANT INFORMATION

Member Materials

Please read this *Schedule of Benefits* and your other Member materials carefully. **This is an important legal document. Please keep it in a safe place.**

- This *Schedule of Benefits* lists the Copayment, Coinsurance, and maximum out-of-pocket amounts for this specific Plan.
- See your *Member Handbook for State, Education, and Local Government Employees ("Member Handbook")* for details of how to use this Plan, such as:
  - Coverage requirements
  - Description of Covered Services and benefit details
  - How and when you reach your maximum out-of-pocket
  - Network of Providers, Referrals, and Preauthorizations
- The *Physicians and Health Providers Directory* ("*Provider Directory*") lists our Network of physicians, Facilities, and pharmacies.
- The *Formulary Drug List for State, Education, and Local Government Employees* ("*Drug Formulary*") lists drugs we cover. It explains the drug Tier and any restrictions for each drug.

When this document says "we", "us", or "our", it means GlobalHealth, Inc. Words or phrases that start with a capital letter are defined in the *Member Handbook* glossary.

Member materials are available on our website. Contact Customer Care for printed copies at no charge. But, be aware that the most current *Drug Formulary* and *Provider Directory* lists are on the website.

Deductible and Maximum Out-of-Pocket

Benefit Description	You Pay
Deductible	This Plan does not have an annual Deductible.
Maximum Out-of-Pocket	Per Member – $3,500 per Plan Year Family – $10,500 per Plan Year

MEDICAL BENEFITS

Devices, Appliances, Equipment, and Supplies

Benefit Description	You Pay
Diabetic Supplies	20% Coinsurance
Durable Medical Equipment ("DME")	20% Coinsurance
Orthotic Devices	20% Coinsurance
Prosthetic Appliances	20% Coinsurance

Emergencies / After Hours

Benefit Description	You Pay
Ambulance	$100 Copayment/occurrence
Emergency Room ("ER") Services	$300 Copayment/visit Waived if admitted to Inpatient Hospital
Urgent Care Facility	$25 Copayment/visit

Family Planning and Maternity Care

Benefit Description	You Pay
Family Planning	Women: No Copayment Men: $50 Copayment/visit if performed in an office setting
Infertility Services	PCP Visit: PCP Visit: No Copayment -OR- Specialist Visit: $50 Copayment/visit Treatment: 50% Coinsurance
Maternity and Newborn Care • Delivery and Inpatient Hospital care for the 48/96 hour birth coverage, including newborn care • Outpatient postnatal care • Prenatal care and other services: o Prenatal care o Breastfeeding pump and supplies o Lactation support and counseling	Delivery and Inpatient Hospital for Mother and Baby: $500 Copayment/admission All Outpatient Postnatal Care: $25 one-time Copayment Prenatal Care and Other Services: No Copayment

Home Care

Benefit Description	You Pay
Applied Behavioral Analysis	Home Visit: No Copayment Natural Environment Training: $50 Copayment/day
Behavioral Health Case Management and Psychosocial Education	No Copayment
Home Healthcare	No Copayment
Hospice Care	No Copayment

Inpatient and Outpatient Care

Benefit Description	You Pay
Behavioral Health, Facility Services	Residential Treatment Center or Medical Detoxification: $250 Copayment/day up to a maximum of $750 per admission Acute Hospitalization: $250 Copayment/day up to $750 Copayment/admission
Inpatient Hospital, Facility Services	Maternity: $500 Copayment/admission All Other Stays: $250 Copayment/day up to $750 Copayment/admission
Inpatient Hospital or Outpatient Surgery, Physician Services	Included in Facility services Copayment
#Outpatient Surgery, Facility Services	Preferred Facility: $250 Copayment -OR- Non-preferred Facility: $750 Copayment
Skilled Nursing Facility Care	$250 Copayment/day up to a maximum of $750 per admission

#You will pay less out-of-pocket if you choose to receive these services in a Preferred Facility rather than a Non-preferred Facility.

Lab and Diagnostic Tests

Benefit Description	You Pay
Lab, X-ray, and Other Diagnostic Tests	No Copayment
#Specialized Scans, Imaging and Diagnostic Exams	PCP Visit: No Copayment -OR- Specialist Visit: Included in Specialist visit Copayment -OR- Preferred Facility: $250 Copayment/scan -OR- Non-preferred: $750 Copayment/scan

#You will pay less out-of-pocket if you choose to receive these services in a Preferred Facility rather than a Non-preferred Facility.

Office Visits

Benefit Description	You Pay
Allergy Care	PCP Visit: No Copayment -OR- Specialist Visit: $50 Copayment/visit

Benefit Description	You Pay
	Serum: $30 Copayment/6-week supply of antigen and administration
(Continued) ***Behavioral Health Services, including Applied Behavioral Analysis***	No Copayment/visit
Chiropractic Care	$25 Copayment/visit
Physician Services	PCP Visit: No Copayment -OR- Specialist Visit: $50

Preventive Care Services

Benefit Description	You Pay
Preventive care	No Copayment Office visit Copayment may apply if in conjunction with other services. See "Physician Services".

Rehabilitation Services

Benefit Description	You Pay
Cardiac and Pulmonary Rehabilitation	$50 Copayment/visit
Physical, Occupational, and/or Speech Therapy	Inpatient: Included in Hospital Facility Copayment $50 Copayment/visit -OR- Rehabilitation Facility: $250 Copayment/day up to $750 Copayment/admission

Special Programs

Benefit Description	You Pay
Special Programs	No Copayment

Temporomandibular Joint Dysfunction

Benefit Description	You Pay
Temporomandibular Joint Dysfunction	$100 Copayment/treatment plan

Treatment Therapies

Benefit Description	You Pay
#Treatment Therapies	$50 Copayment/treatment

Benefit Description	You Pay
[#]You will pay less out-of-pocket if you choose to receive these services in a Preferred Facility rather than a Non-preferred Facility.	

Vision Care

Benefit Description	You Pay
Exam	$50 Copayment/visit
Eyeglasses or Contacts	All charges after maximum reimbursement of $100

PRESCRIPTION DRUGS

Retail Pharmacy – 30-day supply

Benefit Description	You Pay
ACA	No Copayment
Tier One	Low-cost Generic: $5 Copayment/prescription Preferred Generic: $10 Copayment/prescription
Tier Two	$50 Copayment/prescription
Tier Three	$75 Copayment/prescription
Tier Four	Preferred Specialty: $100 Copayment/prescription Non-preferred Specialty: $200 Copayment/prescription

Home Delivery or Extended Retail Supply – 90-day supply

Benefit Description	You Pay
ACA	No Copayment
Tier One	Low-cost Generic: $10 Copayment/prescription Preferred Generic: $20 Copayment/prescription
Tier Two	$100 Copayment/prescription
Tier Three	$150 Copayment/prescription

EXCLUSIONS AND LIMITATIONS

All benefits described below are excluded or limited under this Plan for all types of services.

General Limitations

We cover certain benefits only as follows:

Benefit	Limitation Description
Ancillary services and supplies	• Hearing aids are limited to coverage for: o Children through the month in which he or she turns eighteen (18) years of age, one (1) aid per ear every forty-eight (48) months unless Medically Necessary to replace more often. o Children less than two (2) years of age, four (4) additional ear molds per year. • Corrective lenses and fittings limited to first set of basic frames and lenses (up to $100.00) following cataract surgery. • Routine foot care, shoes, shoe inserts, arch supports, and supportive devices limited to foot care for Members diagnosed with diabetes or peripheral vascular disease. • Orthopedic or corrective shoes limited to those permanently attached to a Denis Browne splint for children. • Wigs and scalp prostheses limited to $150 reimbursement per Plan Year when required due to loss of hair resulting from chemotherapy or radiation therapy. • Breast pumps limited to one (1) per Plan Year for women who are pregnant or nursing. • Orthotic devices limited to: o Members with diagnoses pertaining to peripheral vascular disease or diabetes.
Behavioral health services	• Autism Screening is limited to children at ages eighteen (18) months and twenty-four (24) months. • Developmental Screening is limited to children up to the age of three (3) years. • Compulsive disorders treatment is limited to programs for feeding and eating disorders. • Residential treatment center care limited to 100 days per Plan Year. • Medical detoxification limited to 100 days per Plan Year. • Behavioral health case management limited to eight (8) hours per month and twenty-four (24) hours per Plan Year. • Psychosocial rehabilitation limited to eight (8) hours per month and twenty-four (24) hours per Plan Year. • Psychological testing limited to eight (8) hours per Plan Year. • Psychiatric or psychological treatment for developmental disorders limited to mental retardation, pervasive developmental disorder and other specific disorders, such as autism, Rett's, or Asperger's. • Applied behavioral analysis limited to: o Members under age nine (9) or if not diagnosed or treated until after age three (3) for at least six (6) years;

Benefit	Limitation Description
	○ A maximum of twenty-five (25) hours per week; and ○ A maximum of $25,000 per Plan Year.
Chiropractic care	• Limited to fifteen (15) visits per Plan Year.
Cosmetic services	• Treatment, item, supply, drug, procedure, or any portion of a procedure performed primarily to improve physical appearance limited to: ○ Repairing conditions resulting from an accidental injury; ○ Improvement of the physiological functioning of a malformed body member not related to dentistry or dental processes to the teeth and surrounding tissue; and ○ Breast reconstruction following a mastectomy.
Dental services – medical coverage	• Dentistry or dental processes to the teeth and surrounding tissue limited to: ○ Emergency room services to treat accidental injury to the jaw, sound natural teeth, mouth, or face. ○ Improvement of the physiological functioning of a malformed body member resulting from a congenital defect. • General anesthesia/IV sedation for dental services limited to Members who are: ○ Under the age of nine (9) when he or she has a medical or emotional condition that requires Hospitalization or general anesthesia for dental care; ○ Severely disabled; ○ A minor four (4) years of age or under who, in the judgment of the Practitioner treating the child, is not of sufficient emotional development to undergo a Medically Necessary dental procedure without the use of anesthesia; and ○ Require Inpatient or Outpatient services because of an underlying medical condition and clinical status or because of the severity of the dental procedure.
Experimental or Investigational therapies	• Drugs, items, devices, and procedures limited to: ○ Off-label uses of certain drugs used in the treatment of cancer or the study of oncology; and ○ Certain investigational uses of drugs, including chemotherapy for cancer treatment, if administered as part of an Approved Clinical Trial.
General care or Hospital services	• Hospital private room limited to when the Member is required under the infection control policy of the Hospital to be in isolation to prevent contagion. • Treatment of injuries or illnesses sustained or contracted as the result of being under the influence of any narcotic, unless prescribed by a physician, limited to injury as a result of a medical condition (including both physical and mental health conditions).
Genetic analysis, services, or testing	• Genetic counseling and testing is limited to women whose family history is associated with an increased risk for deleterious mutations in BRCA 1 and BRCA 2 genes.

Benefit	Limitation Description
Home Healthcare	• Limited to 100 visits per Plan Year.
Physical, occupational, and speech therapy	• Physical, occupational, and/or speech therapy services limited to sixty (60) combined visits per Plan Year for you to regain, maintain, or prevent deterioration of a skill or function that has been acquired, but then lost or impaired due to illness, injury, or disabling condition.
Prescription Drugs	• Inhaler extender devices, peak flow meters, Ana-Kits, and EpiPens are limited to three (3) per Plan Year. • Prescription diaphragms are limited to two (2) per Plan Year. • The Pharmacy and Therapeutics Committee's standard quantity limits, prior authorization criteria, and step therapies apply. • Specialty Drugs are limited to a one-month supply. • Smoking cessation products are limited to two (2) full 90-day courses of any FDA-approved tobacco cessation product per Plan Year, if prescribed by your PCP. Limited to Members who are at least eighteen (18) years old. • Drugs prescribed or administered by Out-of-network physicians in non-emergencies is limited to those prescribed by dentists. • Non-prescription contraceptive jellies, ointments, foams, or devices limited to those that are FDA-approved and prescribed by a Network physician for a woman. • Biological sera, medication prescribed for parenteral use or administration, allergy sera, immunizing agents, and immunizing injectable drugs limited to immunizations covered under Preventive Care guidelines and administered at a Network pharmacy. • Prescription drugs for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy, hyporgasmy, or decreased libido limited to post-prostate surgery indications.
Sexual dysfunction	• Services related to sexual dysfunction limited to drugs and supplies for post-prostate surgery indications.
Skilled Nursing Facility care	• Limited to 100 days per Plan Year.
Transgender services	• Limited to individually appropriate Preventive Care services.
Vision	• Routine services limited to one (1) check-up, including eye refraction, per Plan Year. • Treatment for orthoptics or visual training limited to a diagnosis of mild strabismus.

General Excluded Services

The following benefits are not covered:

Benefit	Excluded Service Description
Ancillary services and supplies	• Mattresses and other bedding or bed-wetting alarms.

Benefit	Excluded Service Description
	• Equipment or devices not medical in nature such as braces worn for athletic or recreational use, ear plugs, elastic stockings or supports, or garter belts. • Jacuzzi/whirlpools. • Power-operated vehicles that may be used as wheelchairs. • Purchase or rental of equipment or supplies for common household use including, but not limited to: Physical fitness equipment, traction tables, air conditioners, water purifiers, air-cleaning machines or filtration devices, cervical or lumbar pillows, grab bars, raised toilet seats, shower benches, beds, or chairs. • Bandages, pads, or diapers.
Behavioral health services	• Education, tutoring, and services for the purpose of diagnosing or treating a learning disability, disruptive, impulse-control, or conduct disorder. • Marital counseling.
Dental services – medical coverage	• General dental services. • Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and the alveolar bones). • Correction of occlusive jaw defects, dental implants, or grafting of alveolar ridges. • Treatment of soft tissue for the purpose of facilitating dental procedures or dentures.
Experimental or Investigational therapies	• Drugs, therapies, and technologies whose long-term efficacy or effect is undetermined or unproven or whose efficacy is no greater than that of traditionally accepted standard treatment. • New procedures, services, supplies, and drugs until they are reviewed for safety, efficacy, and cost-effectiveness and approved by GlobalHealth.
General care or Hospital services	• Treatment of any kind which is excessive or not Medically Necessary. • Services received without an authorization, when one is required, and complications arising from those services. • Treatment of any kind received before your start date of coverage or after the time coverage ends, even if authorized. • Care or services provided outside the GlobalHealth Service Area if the need for such care or services could have been foreseen before leaving the Service Area. • Services, other than Hospital services for behavioral health, for which you do not allow the release of information to GlobalHealth. • Services for travel, insurance, licensing, employment, school, camp, sports, premarital, or pre-adoption purposes. • Personal or comfort items. • Services received while outside of the United States (50 states and District of Columbia). • Charges for injuries resulting from war or act of war (whether declared or undeclared) while serving in the military or an auxiliary unit attached

Benefit	Excluded Service Description
	to the military or working in an area of war whether voluntarily or as required by an employer. • Treatment of injuries or illnesses resulting from an attempt or commission of a felony, or as a result of being engaged in an illegal occupation. • Services as a result of recreational drug or alcohol use. • Elective or voluntary enhancement procedures, services, supplies, or medications, including but not limited to: o Hair growth o Sexual performance o Athletic performance o Cosmetic purposes o Anti-aging • Separate charges for missed or canceled appointments, penalty or finance charges, maintenance and/or record-keeping, record copying, or Case Management services. • Treatment, supplies, drugs, and devices for which no charge was made. Treatment, supplies, drugs, and devices for which no payment would be requested if you did not have this coverage. • Custodial care, respite care, homemaker services, or domiciliary care. • Treatment for injury resulting from extreme activities including, but not limited to: o Base jumping o Bungee jumping o Bull riding o Car racing o Skydiving o Motorcycle stunts • Alternative drugs and/or treatments used in the place of standard therapy, to treat any condition or illness. • Screening services requested solely by you, such as commercially advertised heart scans.
Obstetrical and Infertility services	• Elective abortions. • Home uterine monitoring. • Expenses related to surrogate parenthood. • Alternative programs for delivery such as home delivery and use of midwives and birthing centers. • In vitro fertilization, artificial insemination, embryo transfers, reversal of voluntary sterilization, ovum transplant, gamete intrafallopian transfer (“GIFT”), zygote intrafallopian transfer (“ZIFT”), surrogate parenting, and donor semen expenses.
Other coverage	• Treatment for disabilities connected to military service for which you are legally entitled and to which you have reasonable accessibility (i.e., services through a federal governmental agency). • Services that are provided as a result of Workers’ Compensation laws or similar laws.

Benefit	Excluded Service Description
	• Treatment for which the cost is recoverable under any other coverage, including Workers' Compensation, Occupational Disease law, or any state or government agency.
Other Excluded Services	• Services resulting in whole or in part from an excluded condition, item, or service.
Physical, occupational, and speech therapy	• Kinesiology, movement therapy, or biofeedback. • Rolf technique. • Massage therapy. • Acupuncture/acupressure. • Recreational therapy including, but not limited to: o Animal-facilitated therapy o Music therapy
Prescription Drugs	• Drugs and dietary supplements available without a prescription (over-the-counter) or for which there is a non-prescription therapeutic equivalent available, even if ordered by a physician. • Saline and medications for irrigation. • Topical testosterone products (e.g., AndroGel®, Fortesta®, etc.). • Drugs prescribed for a non-FDA approved indication, dosage, or length of therapy.
Repair and replacement	• Drugs, eyewear, devices, appliances, equipment, dental work, or other items that are lost, missing, sold, or stolen. • Items that have been damaged or destroyed due to improper use or abuse.
Transplants	• Artificial or non-human organ transplants or transplants considered experimental, investigative, or unproven. • Donor Screening tests and donor search expenses.
Transportation/lodging	• Routine, non-emergent ambulance transport unless preauthorized by GlobalHealth. • Lodging, meals, and transportation costs.
Vision	• Non-prescription lenses. • LASIK, INTACS, radial keratotomy, and other refractive surgery. • Computer programs of any type, including, but not limited to, those to assist with vision therapy. • Special multifocal ocular implant lenses.
Weight Reduction Programs	• Gastric stapling, gastric balloon services, or any surgical treatment for obesity or weight-loss purposes.

NOTICE ABOUT NON-DISCRIMINATION

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location. All organizations that provide Medicare Advantage plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, and all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

GlobalHealth, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. GlobalHealth does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

GlobalHealth:

- 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 Customer Care at 1-877-280-5600 (toll-free).

If you believe that GlobalHealth 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: ATTN: Compliance Attorney, 701 NE 10th St, Ste. 300, Oklahoma City, OK 73104-5403, Fax: (405) 280-5894, or E-mail: compliance@globalhealth.com. You can file a grievance in person or by mail, fax, or e-mail. If you need help filing a grievance, the Compliance Attorney 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.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-280-5600 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-280-5600 (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1-877-280-5600 (TTY: 711)。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-280-5600 (TTY: 711)번으로 전화해 주십시오.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-280-5600 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل بـ 1-877-280-5600 (TTY: 711).

သတိျပဳရန္ - အကယ္၍ သင္သည္ ျမန္မာစကား ကို ေျပာပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့္အတြက္ စီစဥ္ေဆာင္ရြက္ေပးပါမည္။ ဖုန္းနံပါတ္ 1-877-280-5600 (TTY: 711) သုိ႔ ေခၚဆိုပါ။

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-877-280-5600 (TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-280-5600 (TTY: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-280-5600 (ATS: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-877-280-5600 (TTY: 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-877-280-5600 (TTY: 711).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-877-280-5600 (TTY: 711).

Hagsesda: iyuhno hyiwoniha [tsalagi gawonihisdi]. Call 1-877-280-5600 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با تماس بگیرید. 1-877-280-5600 (TTY: 711)

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