

# Your Benefit Summary

## Canopy 7350 Silver



Providence Signature Network	In-Network	Out-of-Network
Individual Calendar Year Deductible (family amount is 2 times individual)	\$7,350	\$14,700
Individual Out-of-Pocket Maximum (family amount is 2 times individual) This amount includes the deductible.	\$7,350	\$14,700

### Important information about your plan

This summary provides only highlights of your benefits. To view your plan details, register and log in at [www.myProvidence.com](http://www.myProvidence.com).

- In-network and out-of-network deductibles and out-of-pocket maximums accumulate separately.
- Some services and penalties do not apply to out-of-pocket maximums.
- Prior authorization is required for some services.
- Mental Health and Chemical Dependency: (All services, except outpatient provider office visits, must be prior authorized. For information, please call 800-711-4577.)
- View a list of network providers and pharmacies at [www.ProvidenceHealthPlan.com/providerdirectory](http://www.ProvidenceHealthPlan.com/providerdirectory).
- To get the most out of your benefits, use the providers within the Providence Signature network.
- If you choose to go outside the network, you may be subject to billing for charges that are above Usual, Customary and Reasonable charges (UCR). Benefits for out-of-network services are based on these UCR charges.
- Limitations and exclusions apply. See your handbook for details.

Below is the amount you pay after you have met your calendar year deductible

In-Network Services Covered in Full	In-Network	Out-of-Network
<b>On-Demand Provider Visits</b>		
Virtual visits to a Primary Care Provider by phone and video (such as Express Care Virtual) or by Web-direct Visits	Covered in full ✓	Not Covered
Visits to a Provider at a Providence Express Care Retail Health Clinic	Covered in full ✓	Not Applicable
<b>Preventive Care</b>		
Periodic health exams and well-baby care	Covered in full ✓	Covered in full
Routine immunizations and shots	Covered in full ✓	Covered in full
Colonoscopy (preventive, age 50+)	Covered in full ✓	Covered in full
Gynecological exams (1 per calendar year), breast exams and Pap tests	Covered in full ✓	Covered in full
Mammograms	Covered in full ✓	Covered in full
Nutritional Counseling	Covered in full ✓	Covered in full
Tobacco cessation, counseling/classes and deterrent medications	Covered in full ✓	Not Covered

## Your Benefit Summary (continued)

First \$1000 of commonly used in-network services covered in full	Below is the amount you pay after you have met your calendar year deductible	
	In-Network	Out-of-Network
The first \$1000 of allowed amounts is covered in full before the deductible for the following in-network services combined for the calendar year. After \$1000 of combined services, deductible and coinsurance applies. The \$1000 does not apply to your deductible or out-of-pocket maximum.		
Office visits to a Primary Care Provider	First \$1000 of eligible services combined covered in full <sup>✓</sup> then deductible applies. After deductible, Covered in full	Covered in full
Office visits to an Alternative Care Provider (Chiropractic manipulation and acupuncture services are covered separately from the office visit at the levels listed for those benefits.)		Covered in full
Office visits to specialists		Covered in full
Virtual visits to a specialist by phone and video		Not Covered
Urgent care visits (for non-life threatening illness/minor injury)		Covered in full
Outpatient rehabilitative physical therapy (Limited to 30 visits per calendar year combined with occupational therapy and speech therapy; up to 30 additional visits per specified condition. Limits do not apply to Mental Health Services)		Covered in full
Allergy shots and allergy serums		Covered in full
X-ray and lab services		Covered in full
Mental Health outpatient provider visits (For information, please call 800-711-4577.)		Covered in full
Mental Health Applied Behavior Analysis (For information, please call 800-711-4577.)		Covered in full
Mental Health/Chemical Dependency Day treatment, intensive outpatient, and partial hospitalization services (For information, please call 800-711-4577.)		Covered in full

## Other Care and Services

<b>Other Provider Services</b>		
Surgery and anesthesia in an office or facility	Covered in full	Covered in full
Inpatient hospital visits	Covered in full	Covered in full
Injectable and infused medications	Covered in full	Covered in full
<b>Diagnostic Services</b>		
High-tech imaging services (such as PET, CT or MRI)	Covered in full	Covered in full
Sleep studies	30% <sup>✓</sup>	Covered in full
<b>Emergency and Urgent Services</b>		
Emergency services (For emergency medical conditions only. If admitted to the hospital, all services subject to inpatient benefits.)	Covered in full	Covered in full
Emergency medical transportation (air and/or ground) (Emergency transportation is covered under your in-network benefit, regardless of whether or not the provider is an in-network provider.)		Covered in full
<b>Hospital Services</b>		
Inpatient/Observation care	Covered in full	Covered in full
Skilled nursing facility (limited to 60 days per calendar year)	Covered in full	Covered in full
Inpatient rehabilitative care (Limited to 30 days per calendar year; 60 days for head/spinal injuries. Limits do not apply to Mental Health Services.)	Covered in full	Covered in full
Inpatient habilitative care (Limited to 30 days per calendar year; 60 days for head/spinal injuries. Limits do not apply to Mental Health Services.)	Covered in full	Covered in full

## Your Benefit Summary (continued)

	Below is the amount you pay after you have met your calendar year deductible	
	In-Network	Out-of-Network
<b>Outpatient Services</b>		
Outpatient surgery at an ambulatory surgery center or at a hospital-based facility	Covered in full	Covered in full
Colonoscopy (non-preventive) at an ambulatory surgery center or a hospital-based facility	Covered in full	Covered in full
Outpatient dialysis, infusion, chemotherapy and radiation therapy	Covered in full	Covered in full
Outpatient rehabilitative occupational or speech therapy (Limited to 30 visits per calendar year combined with physical therapy; up to 30 additional visits per specified condition. Limits do not apply to Mental Health Services.)	Covered in full	Covered in full
Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year; up to 30 additional visits per specified condition. Limits do not apply to Mental Health Services.)	Covered in full	Covered in full
<b>Maternity Services</b>		
Prenatal visits	Covered in full✓	Covered in full
Delivery and postnatal physician/provider visits	Covered in full	Covered in full
Inpatient hospital/facility services	Covered in full	Covered in full
Routine newborn nursery care	Covered in full	Covered in full
<b>Medical Equipment, Supplies and Devices</b>		
Medical equipment, appliances and supplies	Covered in full	Covered in full
Diabetes supplies (such as lancets, test strips and needles)	30%✓	Covered in full
Prosthetic and orthotic devices (removable custom shoe orthotics are limited to \$200 per calendar year, deductible waived, 30%/50%)	Covered in full	Covered in full
<b>Other Services</b>		
Mental Health and Chemical Dependency Inpatient and residential services (For information, please call 800-711-4577.)	Covered in full	Covered in full
<b>Home Health and Hospice</b>		
Home health care	Covered in full	Covered in full
Hospice care	Covered in full✓	Covered in full✓
Respite care (limited to members receiving Hospice care; limited to 5 consecutive days, up to 30 days per lifetime)	Covered in full	Covered in full
<b>Biofeedback</b>		
Biofeedback for specified diagnosis (limited to 10 visits per lifetime)	Covered in full	Covered in full
<b>Chiropractic Manipulation and Acupuncture</b> (Copayments and coinsurance do not apply to your out-of-pocket maximums)		
Chiropractic manipulations and acupuncture (limited to 10 visits combined per calendar year)	\$25✓	50%✓

## Prescription Drugs

Below is the amount you pay after you have met your calendar year deductible

<b>Up to a 30-Day Supply</b> (From a participating retail, preferred or specialty pharmacy)	
Preferred generic	\$25✓
Non preferred generic	\$45✓
Preferred brand-name	\$75✓
Non-preferred brand-name	50%✓
Specialty	Covered in full
<b>90-Day Supply</b> (From a participating mail order or preferred retail pharmacy)	
Preferred generic	\$75✓
Non preferred generic	\$135✓
Preferred brand-name	\$225✓
Non-preferred brand-name	50%✓

### Pharmacies

Your prescription drug benefit requires that you fill your prescriptions at a participating pharmacy. There are four types of participating pharmacies:

- Retail: a participating pharmacy that allows up to a 30-day supply as outlined in your handbook of short-term and maintenance prescriptions.
- Preferred Retail: a participating pharmacy that allows up to a 90-day supply of maintenance prescriptions and access to up to a 30-day supply of short-term prescriptions.
- Specialty: a participating pharmacy that allows up to a 30-day supply of specialty and self-administered chemotherapy prescriptions. These prescriptions require special delivery, handling, administration and monitoring by your pharmacist.
- Mail Order: a participating pharmacy that allows up to a 90-day supply of maintenance prescriptions and specializes in direct delivery to your home. To order prescriptions by mail, your provider may call in the prescription or you can mail your prescription along with your member identification number to one of our participating mail-order pharmacies.
- View a list of our participating pharmacies [www.ProvidenceHealthPlan.com/planpharmacies](http://www.ProvidenceHealthPlan.com/planpharmacies).

### Using your prescription drug benefit

- To find if a drug is covered under your plan check online at [www.ProvidenceHealthPlan.com/pharmacy](http://www.ProvidenceHealthPlan.com/pharmacy). Note that your plan's formulary includes ACA Preventive drugs which are medications that are covered at no cost when received from participating pharmacies as required by the Patient Protection and Affordable Care Act.
- You may purchase up to a 90-day supply of maintenance drugs using a participating mail-service or preferred retail pharmacy at 3 times the copay. Not all drugs are considered maintenance prescriptions, including compounded drugs and drugs obtained from specialty pharmacies.
- If your brand-name benefit includes a copayment or a coinsurance and you or your provider request or prescribe a brand-name drug when a generic is available, regardless of reason, you will be responsible for the cost difference between the brand-name and generic drug in addition to the brand-name drug copayment or coinsurance indicated on the benefit summary. Your total cost, however, will never exceed the actual cost of the drug.
- Approved non-formulary non-specialty drugs will be covered at the highest non-specialty tier. Approved non-formulary specialty drugs will be covered at the specialty cost sharing tier.
- Compounded medications are prescriptions that are custom prepared by your pharmacist. They must contain at least one FDA-approved drug to be eligible for coverage under your plan. Compounded medications are covered for up to a 30-day supply at a 50% coinsurance after the deductible. Claims are subject to clinical review for medical necessity and are not guaranteed for payment.
- Specialty drugs are prescriptions that require special delivery, handling, administration and monitoring by your pharmacist.
- Most specialty and chemotherapy drugs are only available at our designated specialty pharmacies.
- Certain drugs, devices, and supplies obtained from your pharmacy may apply towards your medical benefit.
- Diabetes supplies may be obtained at your participating pharmacy, and are subject to your group's medical supplies and devices benefit limitations, and coinsurance. See your Member Handbook for details.
- Some prescription drugs require prior authorization for medical necessity, place of therapy, length of therapy, step therapy, or number of doses. If a drug to treat your covered medical condition is not in the formulary, please contact us.
- Self-administered chemotherapy is covered under the Prescription Drug Benefit unless the Outpatient Chemotherapy coverage results in a lower out-of-pocket expense to you. Please refer to your Handbook for more information.
- Self-injectable medications are only covered when they are being self-administered and labeled by the FDA for self-administration; in some cases, a prior authorization may be required for the drug. Documentation of self-administration may also be required. Drugs labeled for self-administration that are being administered by a provider will fall to the member's medical benefit.
- Be sure you present your current Providence Health Plan member identification card.

## Routine Vision Services

### Provided by VSP

Below is the amount you pay after you have met your calendar year deductible

VSP Choice Network (For customer service call 800-877-7195)	Below is the amount you pay after you have met your calendar year deductible	
	In-Network	Out-of-Network
<b>Pediatric Vision Services (under age 19)</b>		
Routine eye exam (limited to 1 exam per calendar year)	Covered in full✓	Covered up to \$45✓
Lenses (limited to 1 pair per calendar year)		
Single vision	Covered in full✓	Covered up to \$30✓
Lined bifocal	Covered in full✓	Covered up to \$50✓
Lined trifocal	Covered in full✓	Covered up to \$70✓
Lenticular lenses	Covered in full✓	Covered up to \$100✓
Frames (limited to 1 pair per calendar year; select from VSP's Otis &Piper™ Eyewear Collection)	Covered in full✓	Covered up to \$70✓
Contact lens services and materials in place of glasses	Covered in full✓	Covered up to \$105✓
Standard: 1 pair per calendar year (1 contact lens per eye)		
Monthly: 6 month supply per calendar year (6 lenses per eye)		
Bi-weekly: 3 month supply per calendar year (6 lenses per eye)		
Dailies: 3 month supply per calendar year (90 lenses per eye)		
<b>Adult Vision Services</b>		
(Copayments do not apply to your out-of-pocket maximums)		
Routine eye exam (limited to 1 exam per 1 calendar year)	\$30✓	Covered up to \$45✓
Lenses (limited to 1 pair per 2 calendar years)		
Single vision	Covered in full✓	Covered up to \$30✓
Lined bifocal	Covered in full✓	Covered up to \$50✓
Lined trifocal	Covered in full✓	Covered up to \$70✓
Lenticular lenses	Covered in full✓	Covered up to \$100✓
Frames (limited to 1 pair per 2 calendar year)	Covered up to \$120✓	Covered up to \$70✓
Contact lens services and materials in place of glasses. (Limited to every 2 calendars years)	Covered up to \$120✓	Covered up to \$105✓

## Pediatric Dental Service (under age 19)

Below is the amount you pay after you have met your calendar year deductible

	In-Network	Out-of-Network If you choose to go outside the dental network, you may be subject to billing for charges that are above the maximum allowable co (MAC)
For customer service, including dental prior authorizations and claims, call 800-878-4445.		
<b>Preventive</b>		
Routine Exams 1 per six months	Covered in full ✓	30% ✓
Bitewing X-rays 1 set per 12 months	Covered in full ✓	30% ✓
Cleanings 2 per 12 months	Covered in full ✓	30% ✓
Topical Fluoride 2 per 12 months	Covered in full ✓	30% ✓
Fissure sealants Under age 16 for 1 service per tooth (molar) every 36 months	Covered in full ✓	30% ✓
Space Maintainers 1 per arch every 24 months	Covered in full ✓	30% ✓
<b>Basic</b>		
Restorative fillings	Covered in full	Covered in full
<b>Major</b>		
Oral surgery (extractions and other minor surgical procedures)	Covered in full	Covered in full
Endodontics and Periodontics	Covered in full	Covered in full
Stainless Steel Crowns/Primary tooth 1 service per tooth in a 7-year period	Covered in full	Covered in full
Porcelain Crowns 1 service per anterior tooth in a 7-year period for children ages 16 and older	Covered in full	Covered in full
Denture and bridge work (construction or repair of fixed bridges, partials and complete dentures) Limited to once every 10 years for member ages 16 and older	Covered in full	Covered in full

## Explanation of terms and phrases

**ACA Preventive Drugs** – ACA Preventive drugs are medications, including contraceptives, which are listed in our formulary, and are covered at no cost when received from Participating Pharmacies as required by the Patient Protection and Affordable Care Act (ACA). Over the counter preventive drugs received from Participating Pharmacies cannot be covered in full without a written prescription from your Qualified Practitioner.

**Coinsurance** – The percentage of the cost that you may need to pay for covered services.

**Copay** – The fixed dollar amount you pay to a healthcare provider for a covered service at the time care is provided.

**Deductible** – The dollar amount that an individual or family pays for covered services before the plan pays any benefits within a calendar year. The following expenses do not apply to the individual or family deductible: services not covered by the plan; fees that exceed usual, customary and reasonable (UCR) charges as established by the plan; penalties incurred if you do not follow the plan's prior authorization requirements; copays and coinsurance for services that do not apply to the deductible.

**Formulary** – A formulary is a list of FDA-approved prescription drugs developed by physicians and pharmacists, designed to offer effective drug treatment choices for covered medical conditions. The Providence Health Plan formulary includes both brand-name and generic medications.

**In-network** – Refers to services received from an extensive network of highly qualified physicians, health care providers and facilities contracted by Providence Health Plan for your specific plan. Generally, your out-of-pocket costs will be less when you receive covered services from in-network providers.

**Limitations and Exclusions** – All covered services are subject to the limitations and exclusions specified for your plan. Refer to your member handbook or contract for a complete list.

**Maintenance Prescriptions** – Medications that are typically prescribed to treat long-term or chronic conditions, such as diabetes, high blood pressure and high cholesterol. Maintenance drugs are those that you have received under our plan for at least 30 days and that you anticipate continuing to use in the future. Compounded and specialty medications are excluded from this definition; and are limited to a 30 day supply.

**Maximum Allowable Charge (MAC)** – A limitation on the billed charges as determined by Providence Health Plan or its authorizing agent by geographic area where the expenses are incurred and may not be less than the negotiated fee for the same service when provided by a Network Dental Provider.

MAC charges do not include sales taxes, handling fees and similar surcharges, and such taxes, fees and surcharges are not covered expenses.

**Non-Formulary Medication** – An FDA-approved drug, generic or brand-name, that is not included in the list of approved formulary medications. These prescriptions require a prior authorization by the health plan and, if approved, will pay at either the highest non-specialty or specialty cost sharing tier.

**Out-of-network** – Refers to services you receive from providers not in your plan's network. Your out-of-pocket costs are generally higher when you receive covered services outside of your plan's network. An out-of-network provider does not have contracted rates with Providence Health Plan and so balance billing may apply. To find an in-network provider, go to [www.ProvidenceHealthPlan.com/providerdirectory](http://www.ProvidenceHealthPlan.com/providerdirectory).

**Out-of-pocket maximum** – The limit on the dollar amount that an individual or family pays for specified covered services in a calendar year. Some services and expenses do not apply to the individual or family out-of-pocket maximum. See your member handbook or contract for details.

**Primary Care Provider** – A qualified physician or practitioner that can provide most of your care and, when necessary, will coordinate care with other providers in a convenient and cost-effective manner.

**Preferred brand-name drugs/non-preferred brand-name drugs** – Brand-name drugs are protected by U.S. patent laws and only a single manufacturer has the rights to produce and sell them. Your benefits include drugs listed on our formulary as preferred brand-name or non-preferred brand-name drugs. Generally your out-of-pocket costs will be less for preferred brand-name drugs.

**Preferred generic drugs/non-preferred generic drugs** – Generic drugs have the same active-ingredient formula as the brand-name drug. Generic drugs are usually available after the brand-name patent expires. Your benefits include drugs listed on our formulary as preferred and non-preferred generic drugs. Generally your out-of-pocket costs will be less for preferred drugs.

**Prescription drug prior authorization** – The process used to request an exception to the Providence Health Plan drug formulary. This process can be initiated by the prescriber of the medication or the member. Some drugs require prior authorization for medical necessity, place of therapy, length of therapy, step therapy or number of doses. Visit us online for additional information at [www.ProvidenceHealthPlan.com](http://www.ProvidenceHealthPlan.com).

**Prior authorization** – Some services must be pre-approved. In-network, your provider will request prior authorization. Out-of-network, you are responsible for obtaining prior authorization.

**Retail Health Clinic** – A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic that is located within a retail operation. A Retail Health Clinic provides same-day visits for basic illness and injuries or preventive services.

## Explanation of terms and phrases (continued)

**Usual, Customary & Reasonable (UCR)** – Describes your plan’s allowed charges for services that you receive from an out-of-network provider. When the cost of out-of-network services exceeds UCR amounts, you are responsible for paying the provider any differences. These amounts do not apply to your out-of-pocket maximums.

**Web-direct Visit** – A consultation with Network Provider using an online questionnaire to collect information to diagnose and treat common conditions such as cold, flu, sore throat, allergies, earaches, sinus pain or UTI.

**Virtual visit** – Visit with a Network Provider using secure internet technology such as Providence Express Care phone and video visits or Web-direct Visits.

## Contact us

Portland Metro Area: 503-574-7500

All other areas: 800-878-4445

TTY:711

[www.ProvidenceHealthPlan.com/contactus](http://www.ProvidenceHealthPlan.com/contactus)



## Non-Discrimination Statement

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Providence Health Plan and Providence Health Assurance:

- Provide 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)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you are a Medicare member who needs these services, call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan or Providence Health Assurance 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 our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance  
Attn: Non-discrimination Coordinator  
PO Box 4158  
Portland, OR 97208-4158

If you need help filing a grievance, and you are a Medicare member call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. (TTY line at 711) for assistance. 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, 1-800-537-7697 (TTY)

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

## Language Access Services

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-878-4445 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-878-4445 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-878-4445 (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 1-800-878-4445 (TTY: 711)。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 11-800-878-4445 (телетайп: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-878-4445 (TTY: 711) 번으로 전화해 주십시오

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 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。1-800-878-4445 (TTY: 711) まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-878-4445 (رقم هاتف الصم والبكم: 711).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-878-4445 (TTY: 711).

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្អិត គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 1-800-878-4445 (TTY: 711)។

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-878-4445 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-878-4445 (TTY: 711).

ف یم باشد یا 1-800-878-4445 تماس دیری بگ. شما یراگان یرا بصورت یربان لات یرتسه، دیکن یم گفتگو یرفارس یربان به اگر: توجه

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-878-4445 (ATS : 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-878-4445 (TTY: 711)

