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, go to www.wellfleetstudent.com or call toll free 1-877-657-5030. 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 1-800-318-2596 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>In-Network Provider: $0; Out-of-Network Provider: $350/ individual; $1,500/ family</td>
<td>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.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. In-Network Preventive care and In-Network Prescription Drugs are covered before you meet your deductible.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>In-Network Provider: $3,250/ individual; $8,100/ family Out-of-Network Provider: $8,500/ individual; $12,100/ family; Prescription Drugs: In-Network Provider: $1,250/individual; $3,500/family; Pediatric Dental: $1,000</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges, and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See Cigna OAP at <a href="http://www.cigna.com">www.cigna.com</a> or call 1-877-657-5030 for a list of network providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$30 copay/visit, 0% coinsurance</td>
<td>35% coinsurance</td>
<td>————none———</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>Chiropractic Care: $30 copay/visit, 15% coinsurance</td>
<td>Chiropractic Care: 35% coinsurance</td>
<td>Chiropractic Care: <strong>Pre-Certification</strong> required.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>Not Covered</td>
<td>————none———</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td>————none———</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$100 copay/visit, 15% coinsurance</td>
<td>35% coinsurance</td>
<td>————none———</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1 (Generic drugs)</td>
<td>Tier 1: $5 copay/prescription</td>
<td>Not Covered</td>
<td>Tier One Prescription copayment: applies to prescriptions filled at UNH Health &amp; Wellness Pharmacy. Tier Two Prescription copayment: applies to prescriptions filled through Benecard. copayment waived for generic contraception medications or medically necessary brand contraceptive medications at either Tier One or Tier Two pharmacy. Up to 30-day supply.</td>
</tr>
<tr>
<td></td>
<td>Tier 2 (Preferred brand drugs)</td>
<td>Tier 1: $25 copay/prescription</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 3 (Non-preferred brand drugs)</td>
<td>Tier 1: $40 copay/prescription</td>
<td>Not Covered</td>
<td></td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the [plan or policy document at www.wellfleetstudent.com.](http://www.wellfleetstudent.com)
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>Specialty drugs</td>
<td></td>
<td>Tier One: $40 copayment/prescription</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tier Two: Generic $15 copayment/prescription</td>
<td>Tier One Prescription copayment: applies to prescriptions filled at UNH Health &amp; Wellness Pharmacy. Tier Two Prescription copayment: applies to prescriptions filled through Benecard. copayment waived for generic contraception medications or medically necessary brand contraceptive medications at either Tier One or Tier Two pharmacy. Up to 30-day supply.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preferred brand: $35 copayment/prescription</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-Preferred brand: $50 copayment/prescription</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>In Physician’s Office or Hospital: $50 copayment/prescription then 15% coinsurance</td>
<td></td>
</tr>
</tbody>
</table>

| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | $100 copayment/surgery, 15% coinsurance | 35% coinsurance |
|                                | Physician/surgeon fees | 15% coinsurance | 35% coinsurance |

| If you need immediate medical attention | Emergency room care | $100 copay/visit, 15% coinsurance | Paid the same as In-Network Provider subject to Usual and Customary Charge. |
|                                         | Emergency medical transportation | $100 copay/trip, 15% coinsurance | Paid the same as In-Network Provider subject to Usual and Customary Charge. |
|                                         | Urgent care | $40 copay/visit, 15% coinsurance | 35% coinsurance |

| If you have a hospital stay | Facility fee (e.g., hospital room) | $250 copay/confainment, 15% coinsurance | 35% coinsurance |
|                            | Physician/surgeon fees | 15% coinsurance | 35% coinsurance |

* For more information about limitations and exceptions, see the plan or policy document at www.wellfleetstudent.com.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
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<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office visits: $30 <strong>copay</strong>/visit, 0% <strong>coinsurance</strong></td>
<td>Outpatient Services, other than office visits: $30 <strong>copay</strong>/visit, 0% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Office visits: <strong>35% coinsurance</strong></td>
<td>Outpatient Services, other than office visits: <strong>35% coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>$250 <strong>copay</strong>/confinement, 15% <strong>coinsurance</strong></td>
<td><strong>35% coinsurance</strong></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>0% <strong>coinsurance</strong></td>
<td><strong>35% coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>$150 <strong>copay</strong>/visit, 15% <strong>coinsurance</strong></td>
<td><strong>35% coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>15% <strong>coinsurance</strong></td>
<td><strong>35% coinsurance</strong></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>15% <strong>coinsurance</strong></td>
<td><strong>35% coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>Inpatient Facility: 15% <strong>coinsurance</strong></td>
<td>Inpatient Facility: <strong>35% coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Outpatient: $30 <strong>copay</strong>/visit, 15% <strong>coinsurance</strong></td>
<td>Outpatient: <strong>35% coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>15% <strong>coinsurance</strong></td>
<td><strong>35% coinsurance</strong></td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at [www.wellfleetstudent.com](http://www.wellfleetstudent.com).
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td></td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td></td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
</tr>
<tr>
<td>Hospice services</td>
<td></td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Children’s eye exam</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>No charge</td>
<td>No charge</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at www.wellfleetstudent.com.
### 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.)**

<table>
<thead>
<tr>
<th>Category</th>
<th>Excluded Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cosmetic surgery</td>
<td></td>
</tr>
<tr>
<td>Dental care (Adult)</td>
<td></td>
</tr>
<tr>
<td>Long-term care</td>
<td></td>
</tr>
<tr>
<td>Routine eye care (Adult)</td>
<td></td>
</tr>
<tr>
<td>Routine foot care</td>
<td></td>
</tr>
<tr>
<td>Weight loss programs</td>
<td></td>
</tr>
</tbody>
</table>

**Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)**

<table>
<thead>
<tr>
<th>Category</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td></td>
</tr>
<tr>
<td>Bariatric surgery (Pre-Certification required)</td>
<td></td>
</tr>
<tr>
<td>Chiropractic care (Pre-Certification required)</td>
<td></td>
</tr>
<tr>
<td>Hearing aids</td>
<td></td>
</tr>
<tr>
<td>Infertility treatment (Pre-Certification required)</td>
<td></td>
</tr>
<tr>
<td>Non-emergency care when traveling outside the U. S.</td>
<td></td>
</tr>
<tr>
<td>Private-duty nursing</td>
<td></td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at [www.wellfleetstudent.com](http://www.wellfleetstudent.com).
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: www.nh.gov/insurance/consumers/health.htm or contact Wellfleet Group, LLC toll free 1-877-657-5030. 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 on how 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: www.nh.gov/insurance/consumers/health.htm.

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? Not Applicable
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:
Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 (877) 657-5030.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijijgo holne' (877) 657-5030.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1146. The time required to complete this information collection is estimated to average 0.08 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
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** $0
- **Specialist copayment** $30
- **Hospital (facility) coinsurance** 15%
- **Other coinsurance** 0%

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

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductibles</strong></td>
<td>$0</td>
</tr>
<tr>
<td><strong>Copayments</strong></td>
<td>$900</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>$300</td>
</tr>
<tr>
<td><strong>What isn't covered</strong></td>
<td>$60</td>
</tr>
</tbody>
</table>

The **total Peg would pay is** $1,260

---

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The **plan's overall deductible** $0
- **Specialist copayment** $30
- **Hospital (facility) coinsurance** 15%
- **Other coinsurance** 0%

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

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductibles</strong></td>
<td>$0</td>
</tr>
<tr>
<td><strong>Copayments</strong></td>
<td>$900</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>$100</td>
</tr>
<tr>
<td><strong>What isn't covered</strong></td>
<td>$10</td>
</tr>
</tbody>
</table>

The **total Joe would pay is** $1,020

---

### Mia’s Simple Fracture
(in-network emergency room visit and follow up care)

- The **plan's overall deductible** $0
- **Specialist copayment** $30
- **Hospital (facility) coinsurance** 15%
- **Other coinsurance** 0%

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

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductibles</strong></td>
<td>$0</td>
</tr>
<tr>
<td><strong>Copayments</strong></td>
<td>$500</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>$100</td>
</tr>
<tr>
<td><strong>What isn't covered</strong></td>
<td>$20</td>
</tr>
</tbody>
</table>

The **total Mia would pay is** $600

---

The plan would be responsible for the other costs of these EXAMPLE covered services.
NOTICE OF NON-DISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

The Company complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Company does not exclude people or treat them worse because of their race, color, national origin, age, disability, or sex.

The Company provides free aids and services to people with disabilities to communicate effectively with us, such as:
1. Qualified sign language interpreters
2. Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose first language is not English when needed to communicate effectively with us, such as:
1. Interpreters
2. Information translated into other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that Wellfleet Insurance Company 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:

Civil Rights Coordinator
PO Box 15369
Springfield, MA 01115-5369
(413) 733-4540
civilcoordinator@wellfleetinsurance.com

You can file a grievance in person, by mail, fax, or email. If you need help filing a grievance our 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
800-868-1019; 800-537-7697 (TDD)

The Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
LANGUAGE ASSISTANCE PROGRAM

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call (877) 657-5030.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al (877) 657-5030.

請注意：如果您說中文 (Chinese) · 我們免費為您提供語言協助服務。請致電：(877) 657-5030.

XIN LƯU Ý: Nếu quý vị nói tiếng Việt (Vietnamese), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi (877) 657-5030.

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. (877) 657-5030번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa (877) 657-5030.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русском (Russian). Позвоните по номеру (877) 657-5030.

 herramienta (Arabic)

ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisyè sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan (877) 657-5030.

ATTENTION : Si vous parlez français (French), des services d’aide linguistique vous sont proposés gratuitement. Veuillez appeler le (877) 657-5030.

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer (877) 657-5030.

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue para (877) 657-5030.

ATTENZIONE: in caso la lingua parlata sia l’italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero (877) 657-5030.

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie (877) 657-5030 an.

注意事項：日本語(Japanese) を話される場合、無料の言語支援サービスをご利用いただけます。(877) 657-5030 にお電話ください。
Kópa ḏya da: Yád ñap ñándé (Hindi) bañsi hätt to ñapke ñape báñsha saññánta sèwàñéj. ñullú uplab hätt. Kópa par kàl kàrâ (877) 657-5030

CEEB TOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov h ru (877) 657-5030.

PAXAD: Nu saritaem ti Illoko (Ilocano), ti serbiso para ti badang ti lengguhe nga awanan bayadna, ket sidadaan para kenam. Maidawat nga awagan iti (877) 657-5030.

Díí BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yánilti’go, saad bee áka’anida’awolígíi, t’áá jiik’eh, bee ná’ahóóti’. T’áá shoodí kohji’ (877) 657-5030 hodilinh.

OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac (877) 657-5030

Gùjarati (Gujarati) Yú nà: Kè támé arasì bìyëtí tà, tò ñín:ñik báñsha sàdà yèwàñéj tñamáñ 5àt ñùbphù 4. Díí kòro (877) 657-5030

ΛΛΗΝΙΚΑ (Greek)ΠΡΟΣΟΧΗ: An miλáte ελληνικά, sth diáθése stás brísñkontai upprèsejs glwssikís uposthrí祁s, oi otopiés paréxontai dwreán. Kaléste (877) 657-5030

Українська (Ukrainian) UBAGA! Yakkó vi rozmoyjáte ukrajynskoyu movou, vi mogote zvernutýsya do bezkoštovnoy slaveby movnoy pídtirimky. Telefnuyite za númerom (877) 657-5030

አማርኛ (Amharic) እንግுፋ: እንግር እንግር እንግር እንግር እንግር እንግር እንግር እንግር እንግር እንግር (877) 657-5030

Punjabi (Punjabi) भाषा लिखित: से नम पूज्यभाषी रेषरे वे, उ वक्ता विठ्ठा मराठी में रुढ़िे करी भएर दखल दिखाते है (877) 657-5030

ລາວ (Lao) ເປັນຊາວ ການບ່ອນຊາວ ການ, ການບ່ອນການບ່ອນຊາວ ເປັນຊາວ, ການບ່ອນຊາວ, ການບ່ອນຊາວ (877) 657-5030