



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](http://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](http://www.healthcare.gov/sbc-glossary) or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	<a href="#">Participating Provider</a> : \$50 / individual; \$100 / family <a href="#">Non-Participating Provider</a> : \$100 / individual; \$200 / family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your deductible?</b>	Yes. <a href="#">Preventive care</a> , and <a href="#">Participating Provider Prescription Drugs</a> expenses are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . 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> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	<a href="#">Participating Provider</a> : \$5,000 / individual; \$10,000 / family <a href="#">Non-Participating Provider</a> : \$6,850 / individual; \$13,700 / family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the out-of-pocket limit?</b>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a network provider?</b>	Yes. See Cigna PPO at <a href="http://www.mycigna.com">www.mycigna.com</a> or call 1-877-657-5030 for a list of <a href="#">participating providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">Non-Participating Provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">Participating Provider</a> might use an <a href="#">Non-Participating Provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a referral to see a specialist?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	none
	<a href="#">Specialist</a> visit	10% <a href="#">coinsurance</a>  Chiropractic Care: 10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>  Chiropractic Care: 40% <a href="#">coinsurance</a>	none
	<a href="#">Preventive care</a> / <a href="#">screening</a> / immunization	No charge	30% <a href="#">coinsurance</a> <a href="#">Deductible</a> does not apply	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	Laboratory Procedures: 10% <a href="#">coinsurance</a>  Radiology Services - Freestanding Facility: \$50 <a href="#">copay</a> /visit 10% <a href="#">coinsurance</a>  Radiology Services - Outpatient Hospital: 10% <a href="#">coinsurance</a>	Laboratory Procedures: 40% <a href="#">coinsurance</a>  Radiology Services - Freestanding Facility \$50 <a href="#">copay</a> /visit 40% <a href="#">coinsurance</a>  Radiology Services - Outpatient Hospital: 40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required but not for Laboratory Procedures.
	Imaging (CT/PET scans, MRIs)	Freestanding Facility \$50 <a href="#">copay</a> /visit 10% <a href="#">coinsurance</a>  Outpatient Hospital: 10% <a href="#">coinsurance</a>	Freestanding Facility \$50 <a href="#">copay</a> /visit 40% <a href="#">coinsurance</a>  Outpatient Hospital: 40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required.

Common Medical Event	Services You May Need	What You Will Pay Participating Provider (You will pay the least)	What You Will Pay Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.wellfleetstudent.com">www.wellfleetstudent.com</a>	Tier 1 (Generic drugs)	\$10 <a href="#">copay</a> /prescription <a href="#">Deductible</a> does not apply	\$10 <a href="#">copay</a> /prescription	Certain <a href="#">Prescription Drugs</a> are not subject to <a href="#">cost sharing</a> when provided in accordance with the comprehensive guidelines supported by HRSA or if the item or service has an "A" or "B" rating. <a href="#">Preauthorization</a> is not required for a Covered <a href="#">Prescription Drugs</a> used to treat a substance disorder, including <a href="#">Prescription Drugs</a> to manage opioid withdrawal and/or stabilization and for opioid overdose reversal. <a href="#">Non-Participating Provider</a> benefits are provided on a reimbursement basis. For 30-day Supply.
	Tier 2 (Preferred brand drugs)	\$25 <a href="#">copay</a> /prescription <a href="#">Deductible</a> does not apply	\$25 <a href="#">copay</a> /prescription	
	Tier 3 (Non-preferred brand drugs)	\$25 <a href="#">copay</a> /prescription <a href="#">Deductible</a> does not apply	\$25 <a href="#">copay</a> /prescription	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	—————none—————
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> Required.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	Benefits will be payable for services received in a hospital emergency department or independent freestanding emergency department. Health care forensic examinations performed under Public Health Law § 2805-l are not subject to <a href="#">cost sharing</a> .
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	Including ground and/or air, water transportation.
	<a href="#">Urgent care</a>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Treatment for non-life-threatening conditions.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Continuous confinement including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care. <a href="#">Preauthorization</a> required. However, <a href="#">Preauthorization</a> is not required for emergency admissions or services provided in a neonatal intensive care unit of a Hospital certified pursuant to Article 28 of the Public Health Law.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Including Oral Surgery, Reconstructive Breast Surgery, Other Reconstructive and corrective surgery; and transplants. <a href="#">Preauthorization</a> required.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.wellfleetstudent.com](http://www.wellfleetstudent.com).

Common Medical Event	Services You May Need	What You Will Pay Participating Provider (You will pay the least)	What You Will Pay Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: 10% <a href="#">coinsurance</a>  Outpatient Services, other than office visits: 10% <a href="#">coinsurance</a>  Opioid Treatment Programs: No charge	Office visits: 40% <a href="#">coinsurance</a>  Outpatient Services, other than office visits: 40% <a href="#">coinsurance</a>  Opioid Treatment Programs: 40% <a href="#">coinsurance</a> <a href="#">Deductible</a> does not apply	Mental Health Care: Including Partial Hospitalization and Intensive Outpatient Program Services. <a href="#">Preauthorization</a> required for surgical services.  Substance Use Services: Including Partial Hospitalization and Intensive Outpatient Program Services and Medication Assisted Treatment. Up to 20 visits/Plan Year may be used for family counseling.
	Inpatient services	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Mental Health Care and Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment). <a href="#">Preauthorization</a> required. However, <a href="#">Preauthorization</a> is not required for emergency admissions; or for Mental Health Care admissions at Participating OMH-licensed Facilities for Members under 18. Also for Substance Use, <a href="#">Preauthorization</a> not required for participating OASAS-certified Facilities.
If you are pregnant	Office visits	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply to <a href="#">Preventive care</a> received at a <a href="#">Participating Provider</a> . Depending on the type of services, <a href="#">copay</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.wellfleetstudent.com](http://www.wellfleetstudent.com).

Common Medical Event	Services You May Need	What You Will Pay Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required.
	<u>Rehabilitation services</u>	Inpatient Facility: 10% <a href="#">coinsurance</a>  Outpatient: 10% <a href="#">coinsurance</a>	Inpatient Facility: 40% <a href="#">coinsurance</a>  Outpatient: 40% <a href="#">coinsurance</a>	Inpatient Rehabilitation Services (Physical, Occupational, and Speech therapies). <a href="#">Preauthorization</a> is required.  Outpatient Includes Physical, Occupational, and Speech therapies. Limited to 60 visits per condition, per Plan Year combined therapies.
	<u>Habilitation services</u>	Inpatient Facility: 10% <a href="#">coinsurance</a>  Outpatient: 10% <a href="#">coinsurance</a>	Inpatient Facility: 40% <a href="#">coinsurance</a>  Outpatient: 40% <a href="#">coinsurance</a>	Inpatient Habilitation Services (Physical, Occupational, and Speech therapies). <a href="#">Preauthorization</a> is required.  Outpatient Includes Physical, Occupational and Speech Therapies. Limited to 60 visits per condition, per Plan Year combined therapies.
	<u>Skilled nursing care</u>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Including Cardiac and Pulmonary Rehabilitation. <a href="#">Preauthorization</a> required.
	<u>Durable medical equipment</u>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Includes braces. <a href="#">Preauthorization</a> is required.
	<u>Hospice services</u>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	none

Common Medical Event	Services You May Need	What You Will Pay Participating Provider (You will pay the least)	What You Will Pay Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If your child needs dental or eye care	Children's eye exam	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	To the end of the month when the Insured Person turns age 19. Limited to 1 exam per Plan Year.
	Children's glasses	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	To the end of the month when the Insured Person turns age 19. Limited to 1 pair of prescribed lenses and frames or contact lenses (in lieu of eyeglasses) per Plan Year.
	Children's dental check-up	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	Limited to 2 exams and cleanings per Plan Year to the end of the month in which the Insured Person turns age 19.

#### 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](#).)

• Bariatric surgery	• Dental care (Adult)	• Private-duty nursing
• Cosmetic surgery	• Long-term care	• Routine foot care
	• Routine eye care (Adult)	• Weight loss programs

##### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

• Acupuncture	• Hearing aids	• Non-emergency care when traveling outside the U.S. (\$1,000 maximum per Plan Year)
• Chiropractic care	• Infertility treatment ( <a href="#">Preauthorization</a> required)	

**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: [https://dfs.ny.gov/consumers/health\\_insurance/new\\_york\\_health\\_insurance\\_policies\\_programs](https://dfs.ny.gov/consumers/health_insurance/new_york_health_insurance_policies_programs). 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](http://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: <http://dfs.ny.gov/consumer/fileacomplaint.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:**

Spanish (Español): Para obtener asistencia en Español, llame al (877) 657-5030.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (877) 657-5030.

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, kwijjigo holne' (877) 657-5030.

***To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.***

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## 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 [Participating Provider](#) pre-natal care and a hospital delivery)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$50
■ <a href="#">Specialist coinsurance</a>	10%
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

**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:**

*Cost Sharing*

<a href="#">Deductibles</a>	\$50
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$1,300

*What isn't covered*

Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,420</b>

### Managing Joe's Type 2 Diabetes

(a year of routine [Participating Provider](#) care of a well- controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$50
■ <a href="#">Specialist coinsurance</a>	10%
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

**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:**

*Cost Sharing*

<a href="#">Deductibles</a>	\$50
<a href="#">Copayments</a>	\$500
<a href="#">Coinsurance</a>	\$200

*What isn't covered*

Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$770</b>

### Mia's Simple Fracture

([Participating Provider](#) emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$50
■ <a href="#">Specialist coinsurance</a>	10%
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

**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:**

*Cost Sharing*

<a href="#">Deductibles</a>	\$50
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$300

*What isn't covered*

Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$360</b>

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: [www.wellfleetstudent.com](http://www.wellfleetstudent.com) or toll free 1-877-657-5030.

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

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.

هذا إذا كنت تتحدث العربية (**Arabic**), نُفِّتُتُمُّعْدَةً عَاصِمًا تَبَوَّلَتْ مِنْجَلًا مَحَاتَمَةً كَلَّا. اَجْرِلَا لِاصْتَلَا + (877) 657-5030

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。

فرازه امشن ابز رگا: (Farsi) جو دشابیم امشن رایتخار دن لگیار روط بی نایز دادما تامدخت، تسا.  
تمس بیگردید. (877) 657-5030

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