



: WellFirst by Medica Silver Copay Plus 4800X01


Coverage for: Individual/Family | Plan Type: EPO



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, [sbc.MO-central.medica.com/individual](#) or call 877-379-7599 (TTY: 711). 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 <https://www.healthcare.gov/sbc-glossary> or call 877-379-7599 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$4,800 / individual \$9,600 / 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> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and preventive prescriptions from <a href="#">network providers</a> 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 <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$9,450 individual / \$18,900 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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , balance billing 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> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="#">MO-central.medica.com/find-a-doctor</a> or call 877-379-7599 (TTY: 711) for a list of <a href="#">network 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="#">out-of-network 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 (balance billing). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a referral.

 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
		Network Provider (You will pay the least)	Out-of-Network 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	\$40 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	Not Covered	No coverage for chiropractic maintenance or long-term therapy.
	<a href="#">Specialist</a> visit	\$80 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	Not Covered	No coverage for infertility services. No coverage for acupuncture.
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not Covered	Services under the Affordable Care Act (ACA) guidelines will be covered as preventive. Services may have a limit on number of visits and/or specific age requirements. For additional information please see the <a href="#">Preventive Services</a> section in your Member Certificate. You may have to pay for services that are not 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)	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	Select diagnostic testing (e.g., genetic testing) and radiology services require <a href="#">prior authorization</a> from our Medical Affairs Division. Failure to obtain <a href="#">prior authorization</a> for any <a href="#">medically necessary</a> covered services which requires an authorization, you, the Member, will be responsible for paying 100% of the total cost.
	Imaging (CT/PET scans, MRIs)	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<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://MO-central.medica.com/Individuals-and-Families/Pharmacy-benefits/Drug-formulary">MO-central.medica.com/Individuals-and-Families/Pharmacy-benefits/Drug-formulary</a>	Preferred generic drugs (Tier 1)	\$15 <a href="#">copay</a> / prescription; <a href="#">deductible</a> does not apply (retail) Mail order maintenance prescriptions, a 90-day supply for 2 <a href="#">copays</a> .	Not Covered (retail and mail order)	None
	Non-Preferred generic, Preferred brand drugs (Tier 2)	\$60 <a href="#">copay</a> / prescription; <a href="#">deductible</a> does not apply (retail) Mail order maintenance prescriptions, a 90-day supply for 3 <a href="#">copays</a> .	Not Covered (retail and mail order)	
	Non-preferred generic, Non-preferred brand drugs (Tier 3)	50% <a href="#">coinsurance</a> / prescription; <a href="#">deductible</a> does not apply (retail) Mail order maintenance prescriptions, a 90-day supply at <a href="#">coinsurance</a> listed above.	Not Covered (retail and mail order)	
	<a href="#">Specialty drugs</a> (Tier 4)	50% <a href="#">coinsurance</a> / prescription; <a href="#">deductible</a> does not apply (retail) Mail order maintenance prescriptions not covered.	Not Covered (retail and mail order)	Infertility drugs not covered (retail and mail order).
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	Select outpatient surgeries require <a href="#">prior authorization</a> from our Medical Affairs Division. Failure to obtain <a href="#">prior authorization</a> for any <a href="#">medically necessary</a> covered services which requires an authorization, you, the Member, will be responsible for paying 100% of the total cost.
	Physician/surgeon fees	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$500 <a href="#">copay</a> /visit and 30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	\$500 <a href="#">copay</a> /visit and 30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Initial emergency services are covered with out-of-network providers
	<a href="#">Emergency medical transportation</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	<a href="#">Urgent care</a>	\$40 <a href="#">copay</a> /visit and/or 30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	\$40 <a href="#">copay</a> /visit and/or 30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Initial <a href="#">urgent care</a> services are covered with <a href="#">out-of-network providers</a> . You may incur a lower <a href="#">copay</a> at an SSM <a href="#">urgent care</a> clinic versus a hospital based facility.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	Elective inpatient admissions and services require <a href="#">prior authorization</a> from our Medical Affairs Division. Failure to obtain <a href="#">prior authorization</a> for any <a href="#">medically necessary</a> covered services which requires an authorization, you, the Member, will be responsible for paying 100% of the total cost.
	Physician/surgeon fees	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 <a href="#">copay</a> /outpatient visit; <a href="#">deductible</a> does not apply	Not Covered	None
	Inpatient services	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	None
If you are pregnant	Office visits	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copayment</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	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	
	Childbirth/delivery facility services	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	
If you need help recovering or have other special health	<a href="#">Home health care</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	100 visits/contract period. Requires <a href="#">prior authorization</a> from our Medical Affairs Division. Failure to obtain <a href="#">prior authorization</a> for any

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
needs				<a href="#">medically necessary</a> covered services which requires an authorization, you, the Member, will be responsible for paying 100% of the total cost.
	<a href="#">Rehabilitation services</a>	Inpatient <a href="#">Rehabilitation services</a> : 30% <a href="#">coinsurance</a> after <a href="#">deductible</a> ; Physical, Occupational and Speech Therapy: \$40 <a href="#">copay</a> /therapy/day; <a href="#">deductible</a> does not apply	Not Covered	Inpatient Rehabilitation Care - 150 days/contract period combined with <a href="#">skilled nursing care</a> . Physical and Occupational Therapy - 20 visits per therapy type/contract period. Speech therapy is unlimited. Services for custodial care are a policy exclusion. Physical, Occupational and Speech Therapy services require <a href="#">prior authorization</a> from our Medical Affairs Division. Failure to obtain <a href="#">prior authorization</a> for any <a href="#">medically necessary</a> covered services which requires an authorization, you, the Member, will be responsible for paying 100% of the total cost.
	<a href="#">Habilitation services</a>	\$40 <a href="#">copay</a> /therapy/day; <a href="#">deductible</a> does not apply	Not Covered	Habilitative therapies - 20 visits per therapy type/contract period. Speech therapy is unlimited. Services for custodial care are a policy exclusion. Physical, Occupational and Speech Therapy services require <a href="#">prior authorization</a> from our Medical Affairs Division. Failure to obtain <a href="#">prior authorization</a> for any <a href="#">medically necessary</a> covered services which requires an authorization, you, the Member, will be responsible for paying 100% of the total cost.
	<a href="#">Skilled nursing care</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	150 days/contract period combined with inpatient rehabilitative confinement. Requires <a href="#">prior authorization</a> from our Medical Affairs Division. Failure to obtain <a href="#">prior authorization</a> for any <a href="#">medically necessary</a> covered services which requires an authorization, you, the

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				Member, will be responsible for paying 100% of the total cost.
	<a href="#">Durable medical equipment</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	<a href="#">Durable medical equipment</a> as stated in our medical policies requires <a href="#">prior authorization</a> from our Medical Affairs Division. Failure to obtain <a href="#">prior authorization</a> for any <a href="#">medically necessary</a> covered services which requires an authorization, you, the Member, will be responsible for paying 100% of the total cost.
	<a href="#">Hospice services</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	Requires <a href="#">prior authorization</a> from our Medical Affairs Division. Failure to obtain <a href="#">prior authorization</a> for any <a href="#">medically necessary</a> covered services which requires an authorization, you, the Member, will be responsible for paying 100% of the total cost.
If your child needs dental or eye care	Children's eye exam	\$40 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	Not Covered	Exams performed by an ophthalmologist will incur the specialty office visit cost share.
	Children's glasses	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	One pair per contract year.
	Children's dental check-up	Not Covered	Not Covered	This policy does not include pediatric dental services as required under the federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your insurance carrier, agent, or the Federally Facilitated Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

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](#).)**

- |  |   |                            |
|--|---|----------------------------|
| • Abortion (except in cases when the life of the mother is endangered) | • Dental care (Adult)                                 | • Routine eye care (Adult) |
| • Acupuncture  | • Infertility Treatment                               | • Routine foot care        |
| • Bariatric Surgery  | • Long-term care                                      | • Weight Loss Programs     |
| • Cosmetic services including surgery                                  | • Non-emergency care when travelling outside the U.S. |                            |

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

- |                     |   |   |
|---------------------|---|---|
| • Chiropractic care | • Hearing aids (Limited to one aid per ear every 36 months) | • Private-duty nursing (Limited to 82 visits per Contract Period) |
|---------------------|---|---|

**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: Medica at 877-379-7599 (TTY: 711) or [MO-central.medicare.com](https://www.medicare.gov); U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>; Missouri Department of Commerce and Insurance at (573) 751-4126 or <https://insurance.mo.gov/consumers>; or Healthcare.gov at [www.Healthcare.gov](http://www.Healthcare.gov) or call 1-800-318-2596. 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: Missouri Department of Commerce and Insurance, Division of Consumer Affairs at <https://insurance.mo.gov/consumers/complaints/index.php> or call 1-800-726-7390.

**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 877-379-7599 (TTY: 711).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 877-379-7599 (TTY: 711).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 877-379-7599 (TTY: 711).

Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwiijigo holne' 877-379-7599 (TTY: 711).

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



## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$4,800
■ <a href="#">Specialist copayment</a>	\$80
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
---------------------------	-----------------

In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$4,800
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$2,300
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$7,170</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$4,800
■ <a href="#">Specialist copayment</a>	\$80
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
---------------------------	----------------

In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$900
<a href="#">Copayments</a>	\$1,200
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,120</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$4,800
■ <a href="#">Specialist copayment</a>	\$80
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
---------------------------	----------------

In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,700
<a href="#">Copayments</a>	\$800
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,500</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

## Discrimination is Against the Law

The Health Plan complies with applicable Federal civil rights laws and will not discriminate against any person based on his or her race, color, creed, religion, national origin, sex, gender, gender identity, health status including mental and physical medical conditions, marital status, familial status, status with regard to public assistance, disability, sexual orientation, age, political beliefs, membership or activity in a local commission, or any other classification protected by law. The Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: TTY communication and written information in other formats such as large print, audio, and braille.
- Provides free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact the number on the back of your identification card. If you believe that we have failed to provide these services or discriminated in another way on the basis of your race, color, creed, religion, national origin, sex, gender, gender identity, health status including mental and physical medical conditions, marital status, familial status, status with regard to public assistance, disability, sexual orientation, age, political beliefs, membership or activity in a local commission, or any other classification protected by law, you can file a grievance with: Civil Rights Coordinator, Mail Route CP250, PO Box 9310, Minneapolis, MN 55443-9310, 952-992-3422, TTY: 711, [civilrightscoordinator@medica.com](mailto:civilrightscoordinator@medica.com).

You can file a grievance in person or by mail, fax, or email. You may also contact the Civil Rights Coordinator if you need assistance with filing a complaint. 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, D.C. 20201 800-368-1019, TTY: 800-537-7697. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

### If you want free help translating this document, call 1-877-317-2410 (TTY: 711).

Si desea recibir asistencia gratuita para la traducción de este documento, llame al 1-877-317-2410.

Yog koj xav tau kev pab dawb txhais daim ntawv no, hu rau 1-877-317-2410.

如果您需要我們免費幫您翻譯此文件，請致電 1-877-317-2410。

Nếu quý vị muốn giúp dịch tài liệu này miễn phí, gọi 1-877-317-2410.

Sanadnikun kaffaltimaleeakkaisiniifhiikamuyoobarbaadd-an 1-877-317-2410 tiinbilbilaa.

إذا كنت ترغب في مساعدة مجانية لترجمة هذا المستند، فاتصل على الرقم 1-877-317-2410.

Если вы хотите получить бесплатную помощь в переводе этого документа, позвоните по телефону 1-877-317-2410.

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອພຣີໃນການແປເອກະສານນີ້, ໃຫ້ໂທຫາ 1-877-317-2410.

Si desea recibir asistencia gratuita para la traducción de este documento, llame al 1-877-317-2410.

Kung nais mo ng libreng tulong sa pagsasalin ng dokumentong ito, tumawag sa 1-877-317-2410.

이 문서를 번역하는 데 무료로 도움을 받고 싶으시면 1-877-317-2410로 전화하십시오.

Si vous désirez obtenir gratuitement de l'aide pour traduire ce document, appelez le 1-877-317-2410.

နမ့်လိဉ်ဘဉ်တၢ်မၤစၢၤကလိလၢတၢ်ကွဲးကျိဉ်ထံလိာ်အံၤအလံၤ, ကိး 1-877-317-2410.

ይህን ስነ፡ ለመተርጎም ነጻ እርዳታ ከፈለጉ በ 1-877-317-2410 ይደውሉ።

Ako želite besplatnu pomoć za prijevod ovog dokumenta, nazovite 1-877-317-2410.

T'áá jiik'é díí naaltsoos t'áá nizaadk'ehjí bee shí ká'adoowoł ninízingo kojí' hodíílnih, 1-877-317-2410.

Wenn Sie kostenlose Hilfe zur Übersetzung dieses Dokuments wünschen, rufen Sie 1-877-317-2410 an.

“यदि आप इस दस्तावेज़ का अनुवाद करने में मुफ्त सहायता चाहते हैं, तो 1-877-317-2410 पर कॉल करें।”

Se desidera ricevere assistenza gratuita per la traduzione di questo documento, chiami il numero 1-877-317-2410.

Jeśli potrzebujesz bezpłatnej pomocy w przetłumaczeniu tego dokumentu, zadzwoń pod numer 1-877-317-2410.

اگر آپ اس دستاویز کا ترجمہ 1-877-317-2410 پر کال کریں کروانے کے لئے مفت مدد چاہتے ہیں، تو