



## **BEST Life** *Plus Silver* Adult Dental Plan

Your oral health is an important part of overall health maintenance. In fact, keeping your mouth healthy helps to keep your whole body healthy and can actually reduce your risk for more serious problems. Did you know that more than 120 medical conditions can be detected in early stages by your dentist?\*

### For adults and dependent children 19 and older

| Adult Benefit                                                                                                                                                                                                 | In-Network                                                                   | Out-of-Network                                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|------------------------------------------------------|
| <b>Annual Maximum</b>                                                                                                                                                                                         | <b>\$1,500</b>                                                               |                                                      |
| <b>Annual Deductible</b><br>Applies to Basic and Major Services (3 per family)                                                                                                                                | You pay the first <b>\$50</b> for individual, up to <b>\$150</b> for family. |                                                      |
| <b>Diagnostic &amp; Preventive Services</b><br>Exams, cleanings, x-rays                                                                                                                                       | You pay <b>0%</b>                                                            | You pay <b>20%</b>                                   |
| <b>Basic Services</b><br>Fillings (amalgam, porcelain & plastic), anterior & posterior composites, emergency palliative treatment, pathology                                                                  | You pay <b>30%</b><br>After 6 month waiting period.                          | You pay <b>50%</b><br>After 6 month waiting period.  |
| <b>Major Services</b><br>Crowns & gold fillings, inlays, onlays & pontics, implants, fixed bridges, complete & partial dentures, oral surgery, anesthesia (general or IV sedation), endodontics, periodontics | You pay <b>60%</b><br>After 12 month waiting period.                         | You pay <b>80%</b><br>After 12 month waiting period. |

*BEST Life has been providing great dental benefits for **over 50 years** with quality plans, affordable rates and superior personal customer service!*

**P.O. BOX 3023  
Meridian, ID 83680-3023**

**(877) 205-8767  
www.bestlife.com**

\* U.S. Surgeon General Report on Oral Health 2000

\*\* The Vision discount plan is not insurance, but a discount plan for supplies and eligible services

This document provides a summary of the plan benefits only. For the official plan details and exclusions and limitations, please refer to the plan policy. BEST Life is a Qualified Dental Plan issuer in the Nevada Health Insurance Marketplace.



# **BEST Life** *Plus Silver* Child Dental Plan



**Satisfies the ACA pediatric dental requirement for children up to age 19**

| Pediatric Benefit                                                                                                                                                                                     | In-Network                                                      | Out-of-Network                                                    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-------------------------------------------------------------------|
| <b>Out-of-Pocket Maximum</b>                                                                                                                                                                          | <b>\$350</b> for 1 child<br><b>\$700</b> for 2 or more children | <b>\$700</b> for 1 child<br><b>\$1,400</b> for 2 or more children |
| <b>Annual Deductible</b><br>Applies to Diagnostic and Preventive services, Basic and Major services received in-network or out-of-network                                                             | You pay the first <b>\$75</b> per child                         | You pay the first <b>\$100</b> per child                          |
| <b>Diagnostic &amp; Preventive Services</b><br>Exams, cleanings, sealants, fluoride treatment, x-rays, space maintainers, emergency palliative treatment                                              | You pay <b>0%</b>                                               | You pay <b>20%</b>                                                |
| <b>Basic Services</b><br>Fillings                                                                                                                                                                     | You pay <b>40%</b>                                              | You pay <b>70%</b>                                                |
| <b>Major Services</b><br>Crowns, prosthodontics, endodontics, periodontics, maxillofacial prosthetics, oral surgery, TMJ treatment, anesthesia, IV sedation, nitrous oxide, analgesia, occlusal guard | You pay <b>50%</b>                                              | You pay <b>70%</b>                                                |
| <b>Orthodontics</b> (medically necessary)                                                                                                                                                             | You pay <b>50%</b>                                              | You pay <b>70%</b>                                                |

## **MORE CHOICE. MORE SAVINGS.**

What dentist you see is completely up to you. However, you can achieve additional savings when you see a dentist within network.

As a BEST Life member, you will have access to the some of the largest national networks available and with rigorous credentialing criteria for providers, you're assured the highest-quality network available.

It's easy to find the best dentists in your area with our Provider Look-Up at: [www.bestlife.com](http://www.bestlife.com).

**When you choose BEST Life, you can rest easy.**  
**Your smiles are safe with us.**



# EyeMed Discount Plan Details

(Plan #9242264)

As a BEST Life customer, you and your dependents receive access to value-added discount programs that can help provide cost savings on vision care, eyewear, and more. These programs are automatically available to all members that are not currently enrolled on a fully-insured vision plan with BEST Life.



| Vision Care Services                  | In-Network                         | Out-of-Network |
|---------------------------------------|------------------------------------|----------------|
| <b>Exam Services</b>                  | <b>\$50</b>                        | Not covered    |
| <b>Contact Lens Fit and Follow-Up</b> |                                    |                |
| • Fit and Follow-up - Standard        | Up to <b>\$10</b> off retail price | Not covered    |
| • Fit and Follow-up - Premium         | <b>100%</b> of retail price        | Not covered    |
| <b>Frame</b>                          | <b>40%</b> off retail price        | Not covered    |
| <b>Lenses</b>                         |                                    |                |
| • Single Vision                       | <b>\$55</b>                        | Not covered    |
| • Bifocal                             | <b>\$75</b>                        | Not covered    |
| • Trifocal                            | <b>\$85</b>                        | Not covered    |
| • Lenticular                          | <b>\$85</b>                        | Not covered    |
| • Progressive - Standard              | <b>\$140</b>                       | Not covered    |
| • Progressive - Premium               | <b>30%</b> off retail price        | Not covered    |
| <b>Lens Options</b>                   |                                    |                |
| • Anti Reflective Coating - Standard  | <b>\$40</b>                        | Not covered    |
| • Anti Reflective Coating - Premium   | <b>30%</b> off retail price        | Not covered    |
| • Polycarbonate - Standard            | <b>\$35</b>                        | Not covered    |
| • Scratch Coating - Standard Plastic  | <b>\$12</b>                        | Not covered    |
| • Tint - Solid and Gradient           | <b>\$12</b>                        | Not covered    |
| • UV Treatment                        | <b>\$12</b>                        | Not covered    |
| • All Other Lens Options              | <b>30%</b> off retail price        | Not covered    |
| <b>Contact Lenses</b>                 |                                    |                |
| • Contacts - Conventional             | <b>15%</b> off retail price        | Not covered    |
| • Contacts - Disposable               | <b>100%</b> of retail price        | Not covered    |



To access these vision plan discounts, members will need a **copy of the discount ID card below** and **locate an EyeMed Advantage network provider** from our website at <https://eyedoclocator.eyemedvisioncare.com/bestlife/en>.

For any other questions, please call  
**(866) 723-0514.**



**BEST Life**<sup>TM</sup>  
BEST Life and Health Insurance Company

Member Name:

Plan #: **9242264**

Network: **EyeMed Advantage Network**

**EyeMed Vision Care® Discount Plan**

Discounts on eye exams, eyewear and eye correction surgery.  
To locate a provider, use our Provider Lookup at [www.bestlife.com](http://www.bestlife.com) or call **866.723.0514**.



## EXCLUSIONS ON PEDIATRIC DENTAL PLAN

This Policy excludes and will not reimburse for the following services or charges.

1. Services provided by anyone other than a doctor of medical dentistry or a doctor of dental surgery, unless a licensed hygienist performs the services under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a dentist.
2. Services received while on active duty with a military service of any country or international organization.
3. Services needed because of participation in a riot or insurrection or the commission of a felony.
4. Services needed as a result of a work related injury or illness, whether or not covered under Worker's Compensation;
5. Services provided by an employer.
6. Services started before Your effective date. Examples of excluded services under this paragraph include but are not limited to the following: obtaining an impression for an appliance, or a modification of one, before Your effective date; preparing a tooth for a crown, bridge or other lab fabricated restorations before Your effective date; opening a pulp chamber for root canal therapy before Your effective date.
7. Services not completed before Your termination date.
8. Services required because You failed to comply with professionally prescribed treatment.
9. Telephone consultation services.
10. Charges for Your failure to keep a scheduled appointment.
11. Services that are primarily for cosmetic reasons. Examples include alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons.
12. Services for orthodontic treatment and orthodontia type procedures unless this Policy defines those services as Covered Services.
13. Charges in excess of the agreed to coverage amounts, as shown on the Schedule of Benefits.
14. Services for correction or alteration of occlusion, or any occlusal adjustments. Expenses incurred for night guards or any other appliances for the correction of harmful habits, except as defined as a Covered Dental Expense.
15. Charges for "safe fees" (e.g., gloves, masks, surgical scrubs and sterilization).
16. Charges for copies of records, charts, x-rays and any other costs associated with the forwarding or mailing of these copies, or for completing dental forms.
17. Charges for state or territorial taxes associated with dental services.
18. Charges for services received from two or more providers for a single procedure or course of care, if those charges would have been less if received from one provider and You made the decision to transfer Your care during the procedure or course of care.
19. Services that are experimental or investigational.
20. Service that are not within the scope of the treating provider's practice.
21. Services that are not Medically Necessary or that would not meet generally accepted standards of practice.
22. Charges that You would not legally have to pay if You did not have insurance, unless mandated by law.
23. Services for specialized procedures and techniques, including precision attachments, personalization, and precious metal bases.
24. Charges for duplicate or provisional services or supplies.
25. Charges for plaque control programs, oral hygiene instruction, and dietary instructions.
26. Charges for gold foil restorations.
27. Charges for treatment at the hospital.
28. Service to adjust a denture or bridgework within six (6) months after it is installed or adjusted, by the same Provider who installed or adjusted it.
29. Charges for home health aides, including but not limited to toothpaste, fluoride gels, dental floss and teeth whiteners.
30. Services to seal teeth, other than permanent molars.
31. Charges to replace lost, stolen or misplaced dentures.
32. Charges to repair or replace damaged, lost or missing appliances.
33. Services to fabricate an athletic mouth guard;
34. Charges for internal bleaching, nitrous oxide, oral sedation, and/or topical medicament centers.
35. Charges for bone grafts in connection with extractions, apicoectomies or non-covered or non-eligible implants.
36. Services received from a family member. "Family member" includes, but is not limited to, a lawful spouse, domestic partner, child, child of a domestic partner, parent, step-parent, grandparent, brother, sister, cousin of the first degree, or in-law.
37. Charges for a Deductible, Coinsurance, or other cost sharing amount for which You are responsible.
38. Temporary services that are considered an integral part of a final services rather than a separate service.
39. Charges for veneers and related procedures.
40. Services not listed as a Covered Service.
41. Services received outside of the United States of America.

## EXCLUSIONS ON SUPPLEMENTAL DENTAL PLAN

This Policy excludes and will not reimburse for the following services or charges.

1. Services provided by anyone other than a doctor of medical dentistry or a doctor of dental surgery, unless a licensed hygienist performs the services under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a dentist.
2. Services received while on active duty with a military service of any country or international organization.
3. Services needed because of participation in a riot or insurrection or the commission of a felony.
4. Services needed as a result of a work related injury or illness, whether or not covered under Worker's Compensation;
5. Services provided by an employer.
6. Services started before Your effective date. Examples of excluded services under this paragraph include but are not limited to the following: obtaining an impression for an appliance, or a modification of one, before Your effective date; preparing a tooth for a crown, bridge or other lab fabricated restorations before Your effective date; opening a pulp chamber for root canal therapy before Your effective date.
7. Services not completed before Your termination date.
8. Services required because You failed to comply with professionally prescribed treatment.
9. Telephone consultation services.
10. Charges for Your failure to keep a scheduled appointment.
11. Services that are primarily for cosmetic reasons. Examples include alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons.
12. Services for orthodontic treatment and orthodontia type procedures unless this Policy defines those services as Covered Services.
13. Charges in excess of the agreed to coverage amounts, as shown on the Schedule of Benefits.
14. Services for correction or alteration of occlusion, or any occlusal adjustments. Expenses incurred for night guards or any other appliances for the correction of harmful habits, except as defined as a Covered Dental Expense.
15. Charges for "safe fees" (e.g., gloves, masks, surgical scrubs and sterilization).
16. Charges for copies of records, charts, x-rays and any other costs associated with the forwarding or mailing of these copies, or for completing dental forms.
17. Charges for state or territorial taxes associated with dental services.
18. Charges for services received from two or more providers for a single procedure or course of care, if those charges would have been less if received from one provider and You made the decision to transfer Your care during the procedure or course of care.
19. Services that are experimental or investigational.
20. Service that are not within the scope of the treating provider's practice.
21. Services that are not Medically Necessary or that would not meet generally accepted standards of practice.
22. Charges that You would not legally have to pay if You did not have insurance, unless mandated by law.
23. Services for specialized procedures and techniques, including precision attachments, personalization, and precious metal bases.
24. Charges for duplicate or provisional services or supplies.
25. Charges for plaque control programs, oral hygiene instruction, and dietary instructions.
26. Charges for gold foil restorations.
27. Charges for treatment at the hospital.
28. Service to adjust a denture or bridgework within six (6) months after it is installed or adjusted, by the same Provider who installed or adjusted it.
29. Charges for home health aides, including but not limited to toothpaste, fluoride gels, dental floss and teeth whiteners.
30. Services to seal teeth, other than permanent molars.
31. Charges to replace lost, stolen or misplaced dentures.
32. Charges to repair or replace damaged, lost or missing appliances.
33. Services to fabricate an athletic mouth guard;
34. Charges for internal bleaching, nitrous oxide, oral sedation, and/or topical medicament centers.
35. Charges for bone grafts in connection with extractions, apicoectomies or non-covered or non-eligible implants.
36. Services received from a family member. "Family member" includes, but is not limited to, a lawful spouse, domestic partner, child, child of a domestic partner, parent, step-parent, grandparent, brother, sister, cousin of the first degree, or in-law.
37. Charges for a Deductible, Coinsurance, or other cost sharing amount for which You are responsible.
38. Temporary services that are considered an integral part of a final services rather than a separate service.
39. Charges for veneers and related procedures.
40. Services not listed as a Covered Service.
41. Services received outside of the United States of America.

## Language Assistance Services

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**ATTENTION:** If you speak another language, language assistance services, free of charge, are available to you. Call 1.877.205.8767 (TTY: 1-855-889-5868).

**Español** (Spanish) **ATENCIÓN:** si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.877.205.8767

**繁體中文** (Chinese) **注意：**如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1.877.205.8767.

**Tiếng Việt** (Vietnamese) **CHÚ Ý:** Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.877.205.8767.

**한국어** (Korean) **주의:** 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.877.205.8767 번으로 전화해 주십시오.

**Tagalog** (Tagalog – Filipino) **PAUNAWA:** Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1.877.205.8767.

**Русский** (Russian) **ВНИМАНИЕ:** Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.877.205.8767.

**عربية** (Arabic) ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.877.205.8767

**Kreyòl Ayisyen** (French Creole) **ATANSYON:** Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1.877.205.8767.

**Français** (French) **ATTENTION :** Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1.877.205.8767.

**Polski** (Polish) **UWAGA:** Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1.877.205.8767.

**Português** (Portuguese) **ATENÇÃO:** Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1.877.205.8767.

**Italiano** (Italian) **ATTENZIONE:** In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1.877.205.8767.

**Deutsch** (German) **ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.877.205.8767.

**日本語** (Japanese) **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。1.877.205.8767 まで、お電話にてご連絡ください

**فارسی** (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1.877.205.8767 تماس بگیرید.

**हिंदी** (Hindi) **ध्यान दें:** यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1.800.368.1019 (TTY: 1.877.205.8767) पर कॉल करें।

**Հայերեն (Armenian)** LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1.877.205.8767 (TTY: 1-xxx-xxx-xxxx).

**ગુજરાતી (Gujarati)** સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1.800.368.1019 (TTY: 1.877.205.8767).

**Hmoob (Hmong)** LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1.877.205.8767.

**اردو (Urdu)** خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں 1.877.205.8767

**ខ្មែរ (Cambodian)** ព្រមជ្រះ : បើសិនជា អ្នក ជា ខ្មែរ , អ្នក ជំនួយ អ ១ យើង គិត ឈរ លើ ថ្លៃ ឥត គិត ថ្លៃ អ្វី ឡើយ ។ 1.800.368.1019 (TTY: 1.877.205.8767)។

**ਪੰਜਾਬੀ (Punjabi)** ਿਧਆਨ ਿਦਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਤਾਸਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1.800.368.1019 (TTY: 1.877.205.8767) 'ਤੇ ਕਾਲ ਕਰੋ।

**বাংলা (Bengali)** ল য় করনঃ যিদ আপিন বাংলা, কথা বলেত পােরন, তাহেল িনঃথরচায় ভাষা সহায়তা পিরেষবা উপল আছ। েফান করন ১ 1.800.368.1019 (TTY: ১1.877.205.8767)।

**יידיש (Yiddish)** אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פון אפצאל. רופן 1.877.205.8767.

**አማርኛ (Amharic)** ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገለግሉት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1.877.205.8767.

**ภาษาไทย (Thai)**เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1.877.205.8767.

**Oroomiffa (Oromo)** XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1.877.205.8767.

**Ilokano (Ilocano)** PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 1.877.205.8767.

**ພາສາລາວ (Lao)** ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1.877.205.8767.

**Shqip (Albanian)** KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1.877.205.8767.

**Srpsko-hrvatski (Serbo-Croatian)** OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1.877.205.8767.

**Українська (Ukrainian)** УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1.877.205.8767.

**नेपाली (Nepali)** ध्यान दनुहोस्: तपाइ ले नेपाल बोल्नहन्छ भन तपाइ को निम्त भाषा सहायता सवाहरु नःशल्क रूपमा उपलब्ध छ । फोन गर्नुहर् ोस् 1.800.368.1019 (ट टवाइ: 1.877.205.8767) ।

**Nederlands (Dutch)** AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige

diensten. Bel 1.877.205.8767.

**Gagana fa'a Sāmoa** (Samoan) MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 1.877.205.8767.

**Kajin Majōl** (Marshallese) LALE: Ñe kwōj kōnono Kajin Majōl, kwomaroñ bōk jēbal in jipañ ilo kajin ñe aṃ ejjelōk wōṇāān. Kaalōk 1.877.205.8767.

**Română** (Romanian) ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1.877.205.8767.

**Foosun Chuuk** (Trukese) MEI AUCHEA: Ika iei foosun fonuomw: Foosun Chuuk, iwe en mei tongeni omw kopwe angei aninisin chiakku, ese kamo. Kori 1.877.205.8767.

**Tonga** (Tongan) FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea teke lava 'o ma'u ia. Telefoni mai 1.877.205.8767.

**Bisaya** (Bisayan) ATENSYON: Kung nagsulti ka og Cebuano, aduna kay magamit nga mga serbisyo sa tabang sa lengguwahe, nga walay bayad. Tawag sa 1.877.205.8767.

**Ikirundi** (Bantu – Kirundi) ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1.877.205.8767.

**Kiswahili** (Swahili) KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1.877.205.8767.

**Bahasa Indonesia** (Indonesian) PERHATIAN: Jika Anda berbicara dalam Bahasa Indonesia, layanan bantuan bahasa akan tersedia secara gratis. Hubungi 1.877.205.8767.

**Türkçe** (Turkish) DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1.877.205.8767 irtibat numaralarını arayın.

ئاگاداری: ئه‌گەر به زمانی کوردی قهسه دهکەیت، خزمەتگوزاریه‌کانی یارمەتی زمان، به‌خۆرای، بۆ تو به‌سه‌سته. پهیوهندی به 1.877.205.8767 پهیوهندی به

**తెలుగు** (Teluga) శ్రద్ధ పెట్టండి: ఒకవేళ మీరు తెలుగు భాష మాట్లాడుతున్నట్లయితే, మీ కొరకు తెలుగు భాషా సహాయక సేవలు ఉచితంగా లభిస్తాయి. 1.800.368.1019 (TTY: 1.877.205.8767) కు కాల్ చేయండి.

**Thuɔŋjaŋ** (Nilotic – Dinka) PIID KENE: Na ye jam nē Thuɔŋjaŋ, ke kuony yenē koc waar thook atō kuka lēu yök abac ke cīn wēnh cuatē piny. Yuopē 1.877.205.8767

**Norsk** (Norwegian) MERK: Hvis du snakker norsk, er gratis språkassistentjenester tilgjengelige for deg. Ring 1.877.205.8767.

**Català** (Catalan) ATENCIÓ: Si parleu Català, teniu disponible un servei d'ajuda lingüística sense cap càrrec. Truqueu al 1.877.205.8767.

**λληνικά** (Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1.877.205.8767.

**Igbo asusu** (Ibo) Ntị: Ọ bụrụ na asụ Ibo, asụsụ aka ọasụ n'efu, defu, aka. Call 1.877.205.8767.

**èdè Yorùbá** (Yoruba) AKIYESI: Bi o ba nsọ èdè Yorùbú ọfẹ̀ ni iranlọwọ̀ lori èdè wa fun yin o. Ẹ pe ẹrọ-ibanisọrọ yi 1.877.205.8767.

**Lokaiahn Pohnpei** (Pohnpeian) Ni songen mwohmw ohte, komw pahn sohte anahne kawehwe mesen nting me koatoantoal kan ahpw wasa me ntingie Lokaiahn Pohnpei komw kalangan oh ntingidieng ni lokaiahn Pohnpei. Call 1.877.205.8767.

**Deitsch** (Pennsylvania Dutch) Wann du Deitsch (Pennsylvania German / Dutch) schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1.877.205.8767.

**ho‘okomo ‘ōlelo** (Hawaiian) E NĀNĀ MAI: Inā ho‘opuka ‘oe i ka ‘ōlelo ho‘okomo ‘ōlelo, loa‘a ke kōkua manuahi iā ‘oe. E kelepona iā 1.877.205.8767.

**Adamawa** (Fulfulde) MAANDO: To a waawi Adamawa, e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1.877.205.8767.

**tsalagi gawonihisdi** (Cherokee) Hagsesda: iyuhno hyiwoniha tsalagi gawonihisdi. Call 877.205.8767

**I linguahén Chamoru** (Chamorro) ATENSIÓN: Yanggen un tungó I linguahén Chamoru, i setbision linguahé gaige para hagu dibatde ha. Agang I 1.877.205.8767.