



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at <http://Ambetter.BuckeyeHealthPlan/> or by calling 877-687-1189, TTY/TDD 877-941-9236

| Important Questions                                       | Answers                                                                                                      | Why this Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|-----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <u>deductible</u> ?                   | <b>\$4,500</b> individual / <b>\$9,000</b> family. Does not apply to preventive care.                        | You must pay all the costs up to the <b><u>deductible</u></b> amount before this plan begins to pay for covered services you use. Check your policy plan or plan document to see when the <b><u>deductible</u></b> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <b><u>deductible</u></b> .                                                                                                             |
| Are there other <u>deductibles</u> for specific services? | No.                                                                                                          | You don't have to meet <b><u>deductibles</u></b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.                                                                                                                                                                                                                                                                                                                                                 |
| Is there an <u>out-of-pocket-limit</u> on my expenses?    | Yes, for network providers <b>\$6,500</b> individual/ <b>\$13,000</b> family. No, for non-network providers. | The <b><u>out-of-pocket limit</u></b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.                                                                                                                                                                                                                                                                                             |
| What is not included in the <u>out-of-pocket limit</u> ?  | Premiums, balance-billed charges, and non-network services this plan doesn't cover.                          | Even though you pay these expenses, they don't count toward the <b><u>out-of-pocket limit</u></b> .                                                                                                                                                                                                                                                                                                                                                                                                         |
| Is there an overall annual limit on what the plan pays?   | No                                                                                                           | The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.                                                                                                                                                                                                                                                                                                                                                                    |
| Does this plan use a <u>network of providers</u> ?        | Yes. See <a href="#">Find a Provider</a> or call 1-877-687-1189 for a list of participating providers.       | If you use an in-network doctor or other health care <b><u>provider</u></b> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b><u>provider</u></b> for some services. Plans use the term in-network, <b><u>preferred</u></b> , or participating for <b><u>providers</u></b> in their <b><u>network</u></b> . See the chart starting on page 2 for how this plan pays different kinds of <b><u>providers</u></b> . |
| Do I need a referral to see a <u>specialist</u> ?         | No, you don't need a referral to see a network specialist.                                                   | You can see the <b><u>specialist</u></b> you choose without permission from this plan; however, prior authorization is required from this plan.                                                                                                                                                                                                                                                                                                                                                             |
| Are there services this plan doesn't cover?               | Yes                                                                                                          | Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about <b><u>excluded services</u></b> .                                                                                                                                                                                                                                                                                                                                      |

**Questions:** Call 877-687-1189, TTY/TDD 877-941-9236 or visit us at <http://Ambetter.BuckeyeHealthPlan/>.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 877-687-1189, TTY/TDD 877-941-9236 to request a copy.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount** you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**).
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

| Common Medical Event                                                                                                                                                       | Services You May Need                            | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|---------------------------------------------|-------------------------------------------------|-------------------------------------------------|
| If you visit a health care <b>provider's</b> office or clinic                                                                                                              | Primary care visit to treat an injury or illness | \$20 Copay/visit                            | Not covered                                     | -----None-----                                  |
|                                                                                                                                                                            | Specialist visit                                 | \$40 Copay/visit                            | Not covered                                     | Prior approval required.                        |
|                                                                                                                                                                            | Other practitioner office visit                  | \$20 Copay/visit                            | Not covered                                     | -----None-----                                  |
|                                                                                                                                                                            | Preventive care/screening/immunization           | No charge                                   | Not covered                                     | -----None-----                                  |
| If you have a test                                                                                                                                                         | Diagnostic test (x-ray, blood work)              | 20% Coinsurance after deductible            | Not covered                                     | Prior approval required.                        |
|                                                                                                                                                                            | Imaging (CT/PET scans, MRIs)                     | 20% Coinsurance after deductible            | Not covered                                     | Prior approval required.                        |
| If you need drugs to treat your illness or condition<br><br>More information about <b>prescription drug coverage</b> is available at <a href="#">Preferred Drug List</a> . | Generic drugs                                    | \$10 Copay                                  | Not covered                                     | -----None-----                                  |
|                                                                                                                                                                            | Preferred brand drugs                            | \$50 Copay                                  | Not covered                                     | Prior approval required.                        |
|                                                                                                                                                                            | Non-preferred brand drugs                        | 20% Coinsurance after deductible            | Not covered                                     | Prior approval required. Subject to deductible. |
|                                                                                                                                                                            | Specialty drugs                                  | 20% Coinsurance after deductible            | Not covered                                     |                                                 |
| If you have outpatient surgery                                                                                                                                             | Facility fee (e.g., ambulatory surgery center)   | 20% Coinsurance after deductible            | Not covered                                     | Prior approval required.                        |
|                                                                                                                                                                            | Physician/surgeon fees                           | 20% Coinsurance after deductible            | Not covered                                     | Prior approval required.                        |

| Common Medical Event                                                   | Services You May Need                        | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|------------------------------------------------------------------------|----------------------------------------------|---------------------------------------------|-------------------------------------------------|--------------------------|
| If you need immediate medical attention                                | Emergency room services                      | 20% Coinsurance after deductible            | 20% Coinsurance after deductible                | -----None-----           |
|                                                                        | Emergency medical transportation             | 20% Coinsurance after deductible            | 20% Coinsurance after deductible                | -----None-----           |
|                                                                        | Urgent care                                  | \$100 Copay                                 | Not covered                                     | -----None-----           |
| If you have a hospital stay                                            | Facility fee (e.g., hospital room)           | 20% Coinsurance after deductible            | Not covered                                     | Prior approval required. |
|                                                                        | Physician/surgeon fee                        | 20% Coinsurance after deductible            | Not covered                                     | Prior approval required. |
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | \$20 Copay                                  | Not covered                                     | Prior approval required. |
|                                                                        | Mental/Behavioral health inpatient services  | 20% Coinsurance after deductible            | Not covered                                     | Prior approval required. |
|                                                                        | Substance use disorder outpatient services   | \$20 Copay                                  | Not covered                                     | Prior approval required. |
|                                                                        | Substance use disorder inpatient services    | 20% Coinsurance after deductible            | Not covered                                     | Prior approval required. |
| If you are pregnant                                                    | Prenatal and postnatal care                  | \$20 Copay                                  | Not covered                                     | Prior approval required. |
|                                                                        | Delivery and all inpatient services          | 20% Coinsurance after deductible            | Not covered                                     | Prior approval required. |

| Common Medical Event                                                  | Services You May Need     | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions                                                                                                                                                                                                 |
|-----------------------------------------------------------------------|---------------------------|---------------------------------------------|-------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>If you need help recovering or have other special health needs</b> | Home health care          | 20% Coinsurance after deductible            | Not covered                                     | Prior approval required. 100 Visit(s) per Year                                                                                                                                                                           |
|                                                                       | Rehabilitation services   | 20% Coinsurance after deductible            | Not covered                                     | Prior authorization required. 60 visits per year. PT, OT, ST limited to 20 visits each, Cardiac limited to 36 visits, Pulmonary limited to 20 visits except if rendered as part of PT, the PT visit limit will apply.    |
|                                                                       | Habilitation services     | 20% Coinsurance after deductible            | Not covered                                     | Prior authorization required. Autism spectrum disorder: Outpatient speech & language therapy and occupational therapy of 20 visits per year per benefit. Outpatient clinical therapeutic intervention of 20 hrs per week |
|                                                                       | Skilled nursing care      | 20% Coinsurance after deductible            | Not covered                                     | Prior authorization required. 90 days per year in a facility                                                                                                                                                             |
|                                                                       | Durable medical equipment | 20% Coinsurance after deductible            | Not covered                                     | Prior approval required.                                                                                                                                                                                                 |
|                                                                       | Hospice service           | 20% Coinsurance after deductible            | Not covered                                     | Prior approval required.                                                                                                                                                                                                 |
| <b>If your child needs dental or eye care</b>                         | Eye exam                  | \$0 Copay/visit                             | Not covered                                     | 1 Visit per year                                                                                                                                                                                                         |
|                                                                       | Glasses                   | \$0 Copay/visit                             | Not covered                                     | 1 Item per year                                                                                                                                                                                                          |
|                                                                       | Dental check-up           | Not covered                                 | Not covered                                     | -----None-----                                                                                                                                                                                                           |

## Excluded Services & Other Covered Services

### Services Your Plan Does Not Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Abortion (Except in cases of rape, incest, or when the life of the mother is endangered)
- Cosmetic surgery
- Long-term care
- Weight loss programs
- Acupuncture
- Dental Care (Adult)
- Non-emergency care when traveling outside the U.S.
- Bariatric surgery
- Hearing aids
- Routine foot care (Not related to diabetes treatment)

## Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care (Limited to 12 specialists' visits per year)
- Routine eye care (Adult)
- Infertility treatment (See policy for coverage details)
- Private-duty nursing (Limited to 90 visits per year)

## Your Rights to Continue Coverage

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 877-687-1189, TTY/TDD 877-941-9236. You may also contact your state insurance department at The Ohio Department of Insurance, 50 W. Town Street Third Floor - Suite 300 Columbus, Ohio 43215, Phone No. (800) 686-1526.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: The Ohio Department of Insurance, 50 W. Town Street Third Floor - Suite 300 Columbus, Ohio 43215, Phone No. (800) 686-1526.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 877-687-1189, TTY/TDD 877-941-9236

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 877-687-1189 (TDD/TTY: 877-941-9236).

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 877-687-1189 (TDD/TTY: 877-941-9236).

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

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## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



### This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays** \$2,700
- **Patient pays** \$4,840

#### Sample care costs:

|                            |                |
|----------------------------|----------------|
| Hospital charges (mother)  | \$2,700        |
| Routine obstetric care     | \$2,100        |
| Hospital charges (baby)    | \$900          |
| Anesthesia                 | \$900          |
| Laboratory tests           | \$500          |
| Prescriptions              | \$200          |
| Radiology                  | \$200          |
| Vaccines, other preventive | \$40           |
| <b>Total</b>               | <b>\$7,540</b> |

#### Patient pays

|                      |                |
|----------------------|----------------|
| Deductibles          | \$4,500        |
| Copays               | \$40           |
| Coinsurance          | \$100          |
| Limits or exclusions | \$200          |
| <b>Total</b>         | <b>\$4,840</b> |

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays** \$2,520
- **Patient pays** \$2,880

#### Sample care costs:

|                                |                |
|--------------------------------|----------------|
| Prescriptions                  | \$2,900        |
| Medical Equipment and Supplies | \$1,300        |
| Office Visits and Procedures   | \$700          |
| Education                      | \$300          |
| Laboratory tests               | \$100          |
| Vaccines, other preventive     | \$100          |
| <b>Total</b>                   | <b>\$5,400</b> |

#### Patient pays

|                      |                |
|----------------------|----------------|
| Deductibles          | \$2,400        |
| Copays               | \$400          |
| Coinsurance          | \$0            |
| Limits or exclusions | \$80           |
| <b>Total</b>         | <b>\$2,880</b> |

## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Examples helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

✖ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

✖ **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✔ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✔ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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## Statement of Non-Discrimination

Ambetter from Buckeye Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Ambetter from Buckeye Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Ambetter from Buckeye Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Ambetter from Buckeye Health Plan at 1-877-687-1189 (TTY/TDD 1-877-941-9236).

If you believe that Ambetter from Buckeye Health Plan 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: Buckeye Health Plan at the Appeals Unit, 4349 Easton Way, Suite 400, Columbus, OH 43219, 1-877-687-1189 (TTY/TDD 1-877-941-9236), Fax 1-866-719-5404. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Ambetter from Buckeye Health Plan 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, 1-800-368-1019, 800-537-7697 (TDD).

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

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|---------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Spanish             | Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Ambetter from Buckeye Health Plan, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-877-678-1189 (TTY/TDD 1-877-941-9236).                                                       |
| Chinese             | 如果您，或是您正在協助的對象，有關於 Ambetter from Buckeye Health Plan 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 1-877-678-1189 (TTY/TDD 1-877-941-9236)。                                                                                                                                                                                             |
| German              | Falls Sie oder jemand, dem Sie helfen, Fragen zum Ambetter from Buckeye Health Plan haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-877-678-1189 (TTY/TDD 1-877-941-9236) an.                                   |
| Arabic              | إن كان لديك أو لدى شخص تساعد أسئلة بخصوص Ambetter from Buckeye Health Plan ، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل ب 1-877-678-1189 (TTY/TDD 1-877-941-9236).                                                                                                      |
| Pennsylvanian Dutch | Wann du hoscht en Froog, odder ebber, wu du helpscht, hot en Froog baut Ambetter from Buckeye Health Plan, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 1-877-678-1189 (TTY/TDD 1-877-941-9236) uffrufe.        |
| Russian             | Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Ambetter from Buckeye Health Plan, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-877-678-1189 (TTY/TDD 1-877-941-9236).                                             |
| French              | Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Ambetter from Buckeye Health Plan, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-877-678-1189 (TTY/TDD 1-877-941-9236).                                      |
| Vietnamese          | Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Buckeye Health Plan, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-877-678-1189 (TTY/TDD 1-877-941-9236).                                                       |
| Cushite-Oromo       | Isin yookan namni biraa isin deeggartan Ambetter from Buckeye Health Plan irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1-877-678-1189 (TTY/TDD 1-877-941-9236) tiin bilbilaa. |

|           |                                                                                                                                                                                                                                                                                   |
|-----------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Korean    | 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Buckeye Health Plan 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-877-678-1189 (TTY/TDD 1-877-941-9236) 로 전화하십시오.                                                                                  |
| Italian   | Se tu o qualcuno che stai aiutando avete domande su Ambetter from Buckeye Health Plan, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-877-678-1189 (TTY/TDD 1-877-941-9236).                      |
| Japanese  | ご本人様、またはお客様の身の回りの方でも、Ambetter from Buckeye Health Planについてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-877-678-1189 (TTY/TDD 1-877-941-9236)までお電話ください                                                                                                    |
| Dutch     | Als u, of iemand die u helpt, vragen heeft over Ambetter from Buckeye Health Plan, heeft u het recht om hulp en informatie te krijgen in uw taal zonder kosten. Om te praten met een tolk, bel 1-877-678-1189 (TTY/TDD 1-877-941-9236).                                           |
| Ukrainian | Якщо у Вас чи у когось, хто отримує Вашу допомогу, виникають питання про Ambetter from Buckeye Health Plan, у Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб зв'язатись з перекладачем, задзвоніть на 1-877-678-1189 (TTY/TDD 1-877-941-9236). |
| Romanian  | Dacă dumneavoastră sau persoana pe care o asistați aveți întrebări privind Ambetter from Buckeye Health Plan, aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a vorbi cu un interpret, sunați la 1-877-678-1189 (TTY/TDD 1-877-941-9236).   |