BEST Life™
BEST Life and Health Insurance Company

ARIZONA

BEST Life Essential Basic 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
Annual Maximum	**$1,000**	
Annual Deductible Applies to Basic and Major Services (3 per family)	You pay the first **$50** for individual, up to **$150** for family.	You pay the first **$75** for individual, up to **$225** for family.
Diagnostic & Preventive Services Exams, cleanings, x-rays	You pay **0%**	You pay **30%**
Basic Services Fillings (amalgam, porcelain & plastic), anterior & posterior composites, emergency palliative treatment, pathology	You pay **50%** After 6 month waiting period.	You pay **70%** After 6 month waiting period.
Major Services Crowns & gold fillings, inlays, onlays & pontics, implants, fixed bridges, complete & partial dentures, oral surgery, anesthesia (general or IV sedation), endodontics, periodontics	You pay **100%**	You pay **100%**
Dental Accident Benefit	Plan pays up to **$100**	
Vision Discount Plan**	Included	

New Benefits This Year!

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

PO Box 19721
Irvine, CA 92623

(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

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BEST Life Essential Basic Child Dental Plan

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

Pediatric Benefit	In-Network	Out-of-Network
Out-of-Pocket Maximum	**$350** for 1 child **$700** for 2 or more children	**$700** for 1 child **$1,400** for 2 or more children
Annual Deductible Applies to Diagnostic and Preventive services, Basic and Major services received in-network or out-of-network	You pay the first **$75** per child	You pay the first **$100** per child
Diagnostic & Preventive Services Exams, cleanings, sealants, fluoride treatment, x-rays, space maintainers, emergency palliative treatment	You pay **0%**	You pay **30%**
Basic Services Minor restorative services, fillings, pulpal treatment, periodontal maintenance, denture adjustment and repair, surgical extractions, anesthesia (general or IV sedation)	You pay **30%**	You pay **60%**
Major Services Major restorative services, crowns & casts, prosthodontics, implants, endodontics, periodontics, occlusal guard	You pay **50%**	You pay **80%**
Orthodontics (medically necessary)	You pay **50%**	You pay **50%**

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.**

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

BEST Life™
BEST Life and Health Insurance Company

eyeMed

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
Exam Services	**$50**	Not covered
Contact Lens Fit and Follow-Up		
• Fit and Follow-up - Standard	Up to **$10** off retail price	Not covered
• Fit and Follow-up - Premium	**100%** of retail price	Not covered
Frame	**40%** off retail price	Not covered
Lenses		
• Single Vision	**$55**	Not covered
• Bifocal	**$75**	Not covered
• Trifocal	**$85**	Not covered
• Lenticular	**$85**	Not covered
• Progressive - Standard	**$140**	Not covered
• Progressive - Premium	**30%** off retail price	Not covered
Lens Options		
• Anti Reflective Coating - Standard	**$40**	Not covered
• Anti Reflective Coating - Premium	**30%** off retail price	Not covered
• Polycarbonate - Standard	**$35**	Not covered
• Scratch Coating - Standard Plastic	**$0**	Not covered
• Tint - Solid and Gradient	**$12**	Not covered
• UV Treatment	**$12**	Not covered
• All Other Lens Options	**30%** off retail price	Not covered
Contact Lenses		
• Contacts - Conventional	**15%** off retail price	Not covered
• Contacts - Disposable	**100%** 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™
BEST Life and Health Insurance Company

eyeMed

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** or call **866.723.0514**.

EXCLUSIONS ON PEDIATRIC DENTAL PLAN

The following exclusions are not covered.

1. Services and treatment not prescribed by or under the direct supervision of a dentist, except in those states where dental hygienists are permitted to practice without supervision by a dentist. In these states, we will pay for eligible covered services provided by an authorized dental hygienist performing within the scope of his or her license and applicable state law.
2. Services and treatment which are experimental or investigational.
3. Services and treatment which are for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under the provision of any law or regulation or any government unit. This exclusion applies whether or not you claim the benefits or compensation.
4. Services and treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, VA hospital or similar person or group.
5. Services and treatment performed prior to your effective date of coverage.
6. Services and treatment incurred after the termination date of your coverage unless otherwise indicated.
7. Services and treatment which are not dentally necessary or which do not meet generally accepted standards of dental practice.
8. Services and treatment resulting from your failure to comply with professionally prescribed treatment.
9. Telephone consultations.
10. Any charges for failure to keep a scheduled appointment.
11. Any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances.
12. Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMJ).
13. Services or treatment provided as a result of intentionally self-inflicted injury or illness.
14. Services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection.
15. Office infection control charges.
16. Charges for copies of your records, charts or x-rays, or any costs associated with forwarding/ mailing copies of your records, charts or x-rays.
17. State or territorial taxes on dental services performed.
18. Those submitted by a dentist, which is for the same services performed on the same date for the same member by another dentist.
19. Those provided free of charge by any governmental unit, except where this exclusion is prohibited by law.
20. Those for which the member would have no obligation to pay in the absence of this or any similar coverage.
21. Those which are for specialized procedures and techniques.
22. Those performed by a dentist who is compensated by a facility for similar covered services performed for members.
23. Duplicate, provisional and temporary devices, appliances, and services.
24. Plaque control programs, oral hygiene instruction, and dietary instructions; Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth.
25. Gold foil restorations.
26. Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan.
27. Treatment of services for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization.
28. Hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient).
29. Charges by the provider for completing dental forms.
30. Adjustment of a denture or bridgework which is made within 6 months after installation by the same dentist who installed it.
31. Use of material or home health aides to prevent decay, such as toothpaste, fluoride gels, dental floss and teeth whiteners.
32. Sealants for teeth other than permanent molars.
33. Precision attachments, personalization, precious metal bases and other specialized techniques.
34. Replacement of dentures that have been lost, stolen or misplaced.
35. Repair of damaged orthodontic appliances.
36. Replacement of lost or missing appliances.
37. Fabrication of athletic mouth guard.
38. Internal bleaching.
39. Nitrous oxide.
40. Oral sedation.
41. Topical medicament center.
42. Bone grafts when done in connection with extractions, apicoectomies or non-covered/non eligible implants.
43. When two or more services are submitted and the services are considered part of the same service to one another the Plan will pay the most comprehensive service (the service that includes the other non-benefited service).
44. When two or more services are submitted on the same day and the services are considered mutually exclusive (when one service contradicts the need for the other service), coverage will only be for the service that represents the final treatment.
45. Charges in excess of any cost-sharing amounts shown on the xchedule of benefits.
46. Expenses incurred for services and supplies not listed as a covered service.
47. Services and supplies performed outside of the U.S.

EXCLUSIONS ON SUPPLEMENTAL DENTAL PLAN

The following exclusions are not covered.

1. Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
2. Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
3. Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
4. Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
5. Services and supplies begun and not completed prior to the patient's effective date, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
6. Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
7. Pulp capping with final restoration. Final restoration is defined as the installation of inlays, onlays or crowns and fillings or other lab fabricated restorations;
8. Charges for tests, examinations, diagnostic casts and oral cancer screenings other than those listed as a Covered Service;
9. Expenses incurred for sedative fillings, prescribed drugs, pre medication or analgesia;
10. The initial installation of a prosthetic device (a fixed bridge, implant, or denture, crowns, inlays and abutments) to replace teeth missing before the Insured was covered under the Policy, except when the installation also replaces a tooth extracted while covered under this plan and commences after the Insured has remained continuously covered under this plan for at least three (3) years immediately prior to the date such installation begins;
11. [Implants, implant services and implant supported prosthetics;]
12. Expenses incurred for veneers and related procedures;
13. Replacement of a lost or stolen or discarded prosthetic device;
14. Adjustment, repairs or relines of prostheses for a period of one (1) year from initial placement if the prostheses were paid for under this plan;
15. Expenses incurred for a core buildup will only be considered in conjunction with a crown;
16. If multiple endodontic treatments are necessary on the same tooth within a period of one (1) year, the allowance will be made for only one (1) procedure;
17. X-rays are considered an integral part of the endodontic procedure rather than a separate service and are therefore not eligible for benefits;
18. The extraction of immature erupting third molars and non-pathologic, asymptomatic third molar extractions;
19. Expenses for gross debridement allowed one time at the beginning of the periodontal treatment plan prior to pocket depth charting;
20. Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
21. Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are a Covered Dental Expense on this Plan;
22. Surgical procedures incidental to orthodontic treatment, including but not limited to, extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate;
23. Charges for service provided for temporomandibular joint dysfunction (TMJ);
24. Expenses incurred for congenital or developmental malformations;
25. Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
26. Any services or supplies 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;
27. Chemotherapeutic agents and any other experimental procedures;
28. Charges in excess of the cost-sharing amounts shown on the Schedule of Benefits;
29. Expenses that are applied toward satisfaction of a Deductible, if any;
30. Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, Your lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
31. Expenses for services for which You would not legally have to pay if there were no insurance;
32. Services not completed on or before the date of termination;
33. If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
34. Any service or procedure not within the scope of practice by a licensed dentist. Such procedures are identified within the current Common Dental Terminology (CDT Codes) published by the American Dental Association;
35. Expenses incurred for treatment which are experimental or investigational;
36. Expenses incurred for services and supplies not listed as a Covered Service;
37. Services and supplies performed outside of the United States of America.
38. Expenses incurred for services covered on a pediatric only dental plan.

Language Assistance Services

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

ارسی (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 નિ:શુલ્ક 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) ប្រយ័ត ៖ េបសិន អ កនិ យ ែខ រ, េស ជំនួយែផ ក េ យមិនគិតឈ ល គឺ ច នសំ ប់បំេអ ក។ ចូរ ទូរស័ព 1.800.368.1019 (TTY: 1.877.205.8767)។

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

বাংলা (Bengali) ল য্ করনঃ যিদ আপিন বাংলা, কথা বলেত পা েরন, তাহেল িনঃখরচায় ভাষা সহায়তা পিরেষবা উপল োেছ। োফান করন ১ 1.800.368.1019 (TTY: ১1.877.205.8767)।

ישיד (Yiddish) אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1.877.205.8767.

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

ภาษาไทย (Thai) **เรียน: ถา ุณพดูภาษาไทยคุณสามารถใชบริการช่วยเหลือทางภาษาไดฟรี 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, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 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 दनुहोस:् तपाइ ले नेपाल बोल्नहन्छ भन तपाइ को निम्त भाषा सहायता सवाहरू नःशल्क रूपमा उपलब्ध छ । फोन गनुहर् ोस ् 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 auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 1.877.205.8767.

Kajin Ṃajōļ (Marshallese) LALE: Ñe kwōj kōnono Kajin Ṃajōļ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeļọk wōṇāān. Kaalọk 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.

وردی (Kurdish) ئاگاداری: ئەگەر بە زمانی کوردی قەسە دەکەیت، خزمەتگوزاریەکانی یارمەتی زمان، بەخۆڕایی، بۆ تۆ بەردەستە. پەیوەندی بە 1.877.205.8767 پەیوەندی بە

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) PIƆ KENE: Na ye jam në Thuɔŋjaŋ, ke kuɔny yenë kɔc waar thook atɔ kuka lëu yök abac ke cïn wënh cuatë piny. Yuɔpë 1.877.205.8767

Norsk (Norwegian) MERK: Hvis du snakker norsk, er gratis språkassistansetjenester 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 ọfé ni iranlọwọ 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.

hoʻokomo ʻōlelo (Hawaiian) E NĀNĀ MAI: Inā hoʻopuka ʻoe i ka ʻōlelo hoʻokomo ʻōlelo, loaʻa ke kōkua manuahi iā ʻoe. 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.