

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual + Family | Plan Type: POS



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 www.HealthReformPlanSBC.com or by calling 1-888-982-3862.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	In-Network: Individual \$100 / Family \$200 . Out-of-Network: Individual \$500 / Family \$1,000 . Does not apply to office visits, prescription drugs, emergency care, inpatient & outpatient hospital services, and preventive care in-network.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	Yes. For prescription drug expenses - Individual \$50 / Family \$150 . Does not apply to generic & Tier 1A drugs in-network. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. In-Network: Individual \$3,500 / Family \$7,000 . Out-of-Network: Individual \$4,000 / Family \$8,000 .	The <u>out-of-pocket limit</u> 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, penalties for failure to obtain pre-authorization for service, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 www.aetna.com or call 1-888-982-3862 for a list of in-network <u>providers</u> .	If you use an in-network doctor or other health care <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without permission 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 5. See your policy or plan document for additional information about <u>excluded services</u> .

Questions: Call 1-888-982-3862 or visit us at www.HealthReformPlanSBC.com. 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.HealthReformPlanSBC.com or call 1-888-982-3862 to request a copy.

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- **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 provider's office or clinic	Primary care visit to treat an injury or illness	\$15 copay/visit	20% coinsurance	Includes Internist, General Physician, Family Practitioner or Pediatrician.
	Specialist visit	\$30 copay/visit	20% coinsurance	—————none—————
	Other practitioner office visit	\$30 copay/visit	20% coinsurance	Coverage is limited to 25 visits per calendar year for Chiropractic care.
	Preventive care /screening /immunization	No charge	20% coinsurance	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	20% coinsurance	—————none—————
	Imaging (CT/PET scans, MRIs)	0% coinsurance	20% coinsurance	—————none—————

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<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at www.aetna.com/pharmacy-insurance/individuals-families</p> <p>Premier Plus Three Tier Open Formulary</p>	<p>Preferred generic drugs (Includes Tier 1A - Value Drugs and Tier 1 Preferred Generic Prescription Drugs)</p>	<p>Copay/prescription (RX): Tier 1A \$3 for 31 day supply, \$6 for 60 day supply, \$9 for 90 day supply (retail); \$6 for 31-90 day supply (mail order); Preferred Generic \$10 for 31 day supply, \$20 for 60 day supply, \$30 for 90 day supply (retail); \$20 for 31-90 day supply (mail order)</p>	<p>Not covered</p>	<p>Covers 31 day supply (retail), 32-60 day supply (retail), 61-90 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for formulary generic FDA-approved women's contraceptives in-network. Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written.</p>
	<p>Preferred brand drugs</p>	<p>Copay/RX: 10% coinsurance with \$20 minimum (min) & \$100 maximum (max) (retail 31 day), \$40 min & \$200 max (retail 60 day), \$60 min & \$300 max (retail 90 day), \$40 for 31-90 day supply (mail order)</p>	<p>Not covered</p>	
	<p>Non-preferred brand drugs</p>	<p>Copay/RX: 10% coinsurance with \$40 min & \$100 max (retail 31 day), \$80 min & \$400 max (retail 60 day), \$120 min & \$300 max (retail 90 day), \$80 for 31-90 day supply (mail order)</p>	<p>Not covered</p>	

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	Specialty drugs	Applicable cost as noted above for generic or brand drugs.	Not covered	First prescription must be filled at a participating retail pharmacy or Aetna Specialty Pharmacy Networks. Subsequent fills must be through Aetna Specialty Pharmacy Networks. Precertification required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$30 copay/visit	20% coinsurance	—————none—————
	Physician/surgeon fees	No charge	20% coinsurance	—————none—————
If you need immediate medical attention	Emergency room services	\$75 copay/visit	\$75 copay/visit	No coverage for non-emergency use.
	Emergency medical transportation	No charge	No charge	No coverage for non-emergency transport.
	Urgent care	\$30 copay/visit	\$30 copay/visit	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$75 copay/stay	20% coinsurance	Pre-authorization required for out-of-network care.
	Physician/surgeon fee	No charge	20% coinsurance	—————none—————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$15 copay/visit	20% coinsurance	—————none—————
	Mental/Behavioral health inpatient services	\$75 copay/stay	20% coinsurance	Pre-authorization required for out-of-network care.
	Substance use disorder outpatient services	\$15 copay/visit	20% coinsurance	—————none—————
	Substance use disorder inpatient services	\$75 copay/stay	20% coinsurance	Pre-authorization required for out-of-network care.
If you are pregnant	Prenatal and postnatal care	No charge	20% coinsurance	—————none—————
	Delivery and all inpatient services	\$75 copay/stay	20% coinsurance	Includes outpatient postnatal care. Pre-authorization may be required for out-of-network care.

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If you need help recovering or have other special health needs	Home health care	0% coinsurance	20% coinsurance	Coverage is limited to 120 visits per calendar year. Pre-authorization required for out-of-network care.
	Rehabilitation services	\$15 copay/visit	20% coinsurance	Coverage is limited to 60 visits per calendar year for Physical, Occupational & Speech Therapy.
	Habilitation services	\$15 copay/visit	20% coinsurance	Coverage is limited to 60 visits per calendar year for Autism Physical, Occupational & Speech Therapy, combined with rehabilitation services.
	Skilled nursing care	\$75 copay/stay	20% coinsurance	Coverage is limited to 90 days per calendar year. Pre-authorization required for out-of-network care.
	Durable medical equipment	No charge	20% coinsurance	—————none—————
	Hospice service	0% coinsurance	20% coinsurance	Pre-authorization required for out-of-network care.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Not covered.
	Glasses	Not covered	Not covered	Not covered.
	Dental check-up	Not covered	Not covered	Not covered.

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 <u>excluded services</u> .)		
<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Cosmetic surgery • Dental care (Adult & Child) 	<ul style="list-style-type: none"> • Glasses (Child) • Long-term care • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Routine eye care (Adult & Child) • Routine foot care • Weight loss programs

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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 - Coverage is limited to 25 visits per calendar year.
- Hearing aids - Coverage is limited to a maximum of \$1,000 per lifetime.
- Infertility treatment - Coverage is limited to the diagnosis and treatment of underlying medical condition.
- Private-duty nursing

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-982-3862. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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 us by calling the toll free number on your Medical ID Card. If your group health plan is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program can help you file your appeal. Contact information is at <http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html>

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 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.**

-----*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 also will 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: \$7,160
- Patient pays: \$380

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
Total	\$7,540

Patient pays:

Deductibles	\$100
Copays	\$80
Coinsurance	\$0
Limits or exclusions	\$200
Total	\$380

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

- Amount owed to providers: \$5,400
- Plan pays: \$4,920
- Patient pays: \$480

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
Total	\$5,400

Patient pays:

Deductibles	\$100
Copays	\$300
Coinsurance	\$0
Limits or exclusions	\$80
Total	\$480

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 Example 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.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-982-3862.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

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

Aetna:

- 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 our Civil Rights Coordinator.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 14462, Lexington, KY 40512, 1-800-648-7817, TTY 711, Fax 859-425-3379, CRCoordinator@aetna.com.

California HMO/HNO Members: Civil Rights Coordinator, PO Box 24030 Fresno CA, 93779, 1-800-648-7817, TTY 711, Fax 860-262-7705, CRCoordinator@aetna.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

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

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates.

TTY: 711

Language Assistance:

For language assistance in your language call 1-888-982-3862 at no cost.

- Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-888-982-3862.
- Amharic - ለቋንቋ እገዛ በ አማርኛ በ 1-888-982-3862 በነጻ ይደውሉ
- Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-888-982-3862
- Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-888-982-3862 առանց գնով:
- Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya.
- Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-888-982-3862 ku busa
- Bengali-Bangala - বাংলা ভাষা সহায়তার জন্য বিনামূল্যে 1-888-982-3862-তে কল করুন।
- Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-982-3862 nga walay bayad.
- Burmese - ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-888-982-3862 ကို ခေါ်ဆိုပါ။
- Catalan - Per rebre assistència en (català), truqui al número gratuït 1-888-982-3862.
- Chamorro - Para ayuda gi fino' (Chamoru), ágang 1-888-982-3862 sin gástu.
- Cherokee - ᎠᎩᎠᎵ ᎠᎵᎠᎵᎠᎵ ᎠᎵᎠᎵᎠᎵ ᎠᎵᎠᎵᎠᎵ ᎠᎵᎠᎵᎠᎵ (GWY) ᎠᎵᎠᎵᎠᎵ 1-888-982-3862 ᎠᎵᎠᎵ ᎠᎵᎠᎵᎠᎵ ᎠᎵᎠᎵᎠᎵ ᎠᎵᎠᎵᎠᎵ.
- Chinese - 欲取得繁體中文語言協助，請撥打 1-888-982-3862，無需付費。
- Choctaw - (Chahta) anumpa ya apela a chi Ꭰ paya hinla 1-888-982-3862.
- Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-888-982-3862 irratti bilisaan bilbilaa.
- Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-888-982-3862.
- French - Pour une assistance linguistique en français appeler le 1-888-982-3862 sans frais.
- French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-982-3862 gratis.
- German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-982-3862 an.
- Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-982-3862 χωρίς χρέωση.
- Gujarati - ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-888-982-3862 પર કોલ કરો.

- Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-888-982-3862. Kāki ‘ole ‘ia kēia kōkua nei.
- Hindi - हन्दिी में भाषा सहायता के लएि, 1-888-982-3862 पर मुफ्त कॉल करें।
- Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-982-3862.
- Ibo - Maka enyemaka asụsụ na Igbo kpọọ 1-888-982-3862 na akwughị ugwo ọ bụla
- Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-982-3862 nga awan ti bayadanyo.
- Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-982-3862.
- Japanese - 日本語で援助をご希望の方は、1-888-982-3862 まで無料でお電話ください。
- Karen - လၢတၢ်မၤစၢၤတၢ်ကတိၢ်ကျိၢ်အဂီၢ် ကျိၢ် လိး 1-888-982-3862 လၢတၢ်အိၣ်ဒီးတၢ်လၢတၢ်ဘျၣ်လၢတၢ်စ့ဘၣ်
- Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862번으로 전화해 주십시오.
- Kru-Bassa - Ɓe'm`ké gbo-kpá-kpá dyé pídyi dé Ɓašwá-wuḍuũn wɛɛ, dá 1-888-982-3862
- Kurdish - برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 به خورایی په یومندی بکمن.
- Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-888-982-3862 ໂດຍບໍ່ເສຍຄ່າໂທ.
- Marathi - तीलभाषा (मराठी) सहाय्यासाठी 1-888-982-3862 क्रमांकावरकोणत्याहीखर्चाशवियकॉलकरा.
- Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-888-982-3862 ilo ejjelok wōnān.
- Micronesian-Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-982-3862 ni sohte isais.
- Mon-Khmer, Cambodian - សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទទេៅកាន់លេខ 1-888-982-3862 ដោយឥតគិតថ្លៃ។
- Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-888-982-3862
- Nepali - (नेपाली) मा नःशुल्क भाषा सहायता पाउनका लागि 1-888-982-3862 मा फोन गर्नुहोस् ।
- Nilotic-Dinka - Tën kuwoɲy ë thok ë Thuonjän col 1-888-982-3862 kecin ayöc.
- Norwegian - For språkassistanse på norsk, ring 1-888-982-3862 kostnadsfritt.
- Panjabi - ਪੰਜਾਬੀ ਵੱਚਿ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-982-3862 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।
- Pennsylvania Dutch - Fer Hilfe in Deutsch, ruf: 1-888-982-3862 aa. Es Aaruf koschtet nix.
- Persian - برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
- Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-982-3862.

Portuguese -	Para obter assistência linguística em português ligue para o 1-888-982-3862 gratuitamente.
Romanian -	Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-888-982-3862
Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-888-982-3862.
Samoan -	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-888-982-3862 e aunoa ma se totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-888-982-3862.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-888-982-3862.
Sudanic-Fulfude -	Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-888-982-3862. Njodi woo fawaaki on.
Swahili -	Ukikitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-888-982-3862 bila malipo.
Syriac -	ܟܠ ܗܘܢܐ ܟܠ ܗܘܢܐ ܠܗܘܢܐ ܟܠ ܗܘܢܐ ܟܠ ܗܘܢܐ ܟܠ ܗܘܢܐ ܟܠ ܗܘܢܐ ܟܠ ܗܘܢܐ ܟܠ ܗܘܢܐ ܟܠ ܗܘܢܐ 1-888-982-3862 ܟܠ ܗܘܢܐ .
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-982-3862 nang walang bayad.
Telugu -	చౌషి నాయం కేరకం ఎలంటి ఖరీచా లకీంద 1-888-982-3862 కు కలీ చీయండీ. (అలంగ)
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-888-982-3862 ฟรีไม่มีค่าใช้จ่าย
Tongan -	Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-888-982-3862 'o 'ikai hā tōtōngi.
Trukese -	Ren ánnisin chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-888-982-3862 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemedi 1-888-982-3862.
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-982-3862.
Urdu -	اوریکل کتنفام رپ 1-888-982-3862 اعمین لول لی م ودر
Vietnamese -	Đê được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-888-982-3862.
Yiddish -	פאר שפראך הילף אין אידיש רופט 1-888-982-3862 פון אפצאל.
Yoruba -	Fún ìrànlowọ nípa èdè (Yorùbá) pe 1-888-982-3862 láí san owó kankan rárá.

Submission: XX_MMS_POS_000000-000000-000184_XXCHOICEPOI_010112_V020614.xlsm

Imported: 3/30/2017 5:17:00 PM

Analysis: Last Error Analysis: 3/30/2017 7:49:12 PM

Recalculate

There are no Validation Errors