



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit <https://benefits.sonypictures.com> or by calling 1-888-385-1053. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-888-982-3862 to request a copy.

| Important Questions                                         | Answers                                                                                                                                       | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|-------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall deductible?                             | In-Network: EE Only \$1,750; EE+ Family \$3,500. Out-of-Network: EE Only \$3,500; EE+ Family \$7,000.                                         | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.                                                                                                                                                                                                                         |
| Are there services covered before you meet your deductible? | Yes. In-network preventive care is covered before you meet your deductible.                                                                   | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>                     |
| Are there other deductibles for specific services?          | No.                                                                                                                                           | You don't have to meet deductibles for specific services.                                                                                                                                                                                                                                                                                                                                                                                                            |
| What is the out-of-pocket limit for this plan?              | In-Network: EE Only \$4,000; EE+ Family: Individual \$6,850/ Family \$8,000. Out-of-Network: EE Only \$8,000; EE+ Family \$16,000.            | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.                                                                                                                                                                                                                         |
| What is not included in the out-of-pocket limit?            | Premiums, balance-billing charges, health care this plan doesn't cover & penalties for failure to obtain pre-authorization for services.      | Even though you pay these expenses, they don't count toward the out-of-pocket limit.                                                                                                                                                                                                                                                                                                                                                                                 |
| Will you pay less if you use a network provider?            | Yes. For in-network providers, see <a href="http://www.aetna.com/dsepublic/#/sony">www.aetna.com/dsepublic/#/sony</a> or call 1-888-385-1053. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do you need a referral to see a specialist?                 | No.                                                                                                                                           | You can see the specialist you choose without a referral.                                                                                                                                                                                                                                                                                                                                                                                                            |



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event                                                                                                                                                                                                                                                               | Services You May Need                            | What You Will Pay                                                                                                                                                |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                    |                                                  | In-Network Provider<br>(You will pay the least)                                                                                                                  | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| If you visit a health care provider's office or clinic                                                                                                                                                                                                                             | Primary care visit to treat an injury or illness | 20% <u>coinsurance</u>                                                                                                                                           | 40% <u>coinsurance</u>                             | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                                                                                                    | Specialist visit                                 | 20% <u>coinsurance</u>                                                                                                                                           | 40% <u>coinsurance</u>                             | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                                                                                                    | Preventive care / <u>screening</u> /immunization | No charge                                                                                                                                                        | 20% <u>coinsurance</u>                             | You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.                                                                                                                                                                                                                                                                                                                                                                                                                         |
| If you have a test                                                                                                                                                                                                                                                                 | Diagnostic test (x-ray, blood work)              | 20% <u>coinsurance</u>                                                                                                                                           | 40% <u>coinsurance</u>                             | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                                                                                                    | Imaging (CT/PET scans, MRIs)                     | 20% <u>coinsurance</u>                                                                                                                                           | 40% <u>coinsurance</u>                             | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| If you need drugs to treat your illness or condition<br><br><b><u>Prescription drug coverage is administered by CVS/Caremark</u></b><br><br>More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.Caremark.com">www.Caremark.com</a> | Generic drugs                                    | \$10 <u>copay</u> /prescription (retail);<br>\$20 <u>copay</u> /prescription (mail order)                                                                        | Not covered                                        | Maintenance prescriptions: Must be filled at a participating CVS, Kroger, or Costco retail pharmacy or through mail order; mail order cost share applies, covers 90-day supply.<br>All other prescriptions: Covers up to 30-day supply (retail prescription); 31-90 day supply (mail order prescription).<br><br>Certain specialty pharmacy drugs are considered non-essential health benefits and fall outside the out-of-pocket limits. The cost of these drugs (though reimbursed by the manufacturer at no cost to you) will not be applied towards satisfying your out-of-pocket maximums. |
|                                                                                                                                                                                                                                                                                    | Preferred brand drugs                            | 30% <u>coinsurance</u> (retail - minimum \$25/prescription; maximum \$75/prescription);<br>(mail order - minimum \$55/prescription; maximum \$125/prescription)  | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                                                                                                    | Non-preferred brand drugs                        | 40% <u>coinsurance</u> (retail - minimum \$40/prescription; maximum \$100/prescription);<br>(mail order - minimum \$70/prescription; maximum \$150/prescription) | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |

| Common Medical Event                                                      | Services You May Need                          | What You Will Pay                                                |                                                            | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                           |
|---------------------------------------------------------------------------|------------------------------------------------|------------------------------------------------------------------|------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                | In-Network Provider<br>(You will pay the least)                  | Out-of-Network Provider<br>(You will pay the most)         |                                                                                                                                                                                                                                                                  |
|                                                                           | <u>Specialty drugs</u>                         | <u>Specialty Drugs</u> follow the respective tier's cost sharing | Not covered                                                | None                                                                                                                                                                                                                                                             |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center) | 20% <u>coinsurance</u>                                           | 40% <u>coinsurance</u>                                     | None                                                                                                                                                                                                                                                             |
|                                                                           | Physician/surgeon fees                         | 20% <u>coinsurance</u>                                           | 40% <u>coinsurance</u>                                     | None                                                                                                                                                                                                                                                             |
| If you need immediate medical attention                                   | <u>Emergency room care</u>                     | 20% <u>coinsurance</u>                                           | 20% <u>coinsurance</u>                                     | Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . No coverage for non-emergency use. Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . Non-emergency transport: not covered, except if pre-authorized.         |
|                                                                           | <u>Emergency medical transportation</u>        | 20% <u>coinsurance</u>                                           | 20% <u>coinsurance</u>                                     |                                                                                                                                                                                                                                                                  |
|                                                                           | <u>Urgent care</u>                             | 20% <u>coinsurance</u>                                           | 40% <u>coinsurance</u>                                     | No coverage for non-urgent use.                                                                                                                                                                                                                                  |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)             | 20% <u>coinsurance</u>                                           | 40% <u>coinsurance</u>                                     | Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.                                                                                                                                                                         |
|                                                                           | Physician/surgeon fees                         | 20% <u>coinsurance</u>                                           | 40% <u>coinsurance</u>                                     | None                                                                                                                                                                                                                                                             |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                            | Office & other outpatient services: 20% <u>coinsurance</u>       | Office & other outpatient services: 40% <u>coinsurance</u> | None                                                                                                                                                                                                                                                             |
|                                                                           | Inpatient services                             | 20% <u>coinsurance</u>                                           | 40% <u>coinsurance</u>                                     | Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.                                                                                                                                                                         |
| If you are pregnant                                                       | Office visits                                  | No charge                                                        | 40% <u>coinsurance</u>                                     | Cost sharing does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply. |
|                                                                           | Childbirth/delivery professional services      | 20% <u>coinsurance</u>                                           | 40% <u>coinsurance</u>                                     |                                                                                                                                                                                                                                                                  |
|                                                                           | Childbirth/delivery facility services          | 20% <u>coinsurance</u>                                           | 40% <u>coinsurance</u>                                     |                                                                                                                                                                                                                                                                  |
| If you need help recovering or have other special health needs            | <u>Home health care</u>                        | 20% <u>coinsurance</u>                                           | 40% <u>coinsurance</u>                                     | 120 visits/calendar year. Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.                                                                                                                                               |
|                                                                           | <u>Rehabilitation services</u>                 | 20% <u>coinsurance</u>                                           | 40% <u>coinsurance</u>                                     | 75 visits/calendar year for Physical, Occupational & Speech Therapy combined. No coverage for therapeutic services offered in an educational setting.                                                                                                            |
|                                                                           | <u>Habilitation services</u>                   | 20% <u>coinsurance</u>                                           | 40% <u>coinsurance</u>                                     | No coverage for therapeutic services offered in an educational setting.                                                                                                                                                                                          |

| Common Medical Event                          | Services You May Need            | What You Will Pay                               |                                                    | Limitations, Exceptions, & Other Important Information                                                           |
|-----------------------------------------------|----------------------------------|-------------------------------------------------|----------------------------------------------------|------------------------------------------------------------------------------------------------------------------|
|                                               |                                  | In-Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                  |
|                                               | <u>Skilled nursing care</u>      | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | 120 days/calendar year. Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care. |
|                                               | <u>Durable medical equipment</u> | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.       |
|                                               | <u>Hospice services</u>          | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.                         |
| <b>If your child needs dental or eye care</b> | Children's eye exam              | Not covered                                     | Not covered                                        | You may have other vision coverage not described here.                                                           |
|                                               | Children's glasses               | Not covered                                     | Not covered                                        | You may have other vision coverage not described here.                                                           |
|                                               | Children's dental check-up       | Not covered                                     | Not covered                                        | You may have other dental coverage not described here.                                                           |

#### Excluded Services & Other Covered Services:

##### Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult & Child)
- Routine foot care
- Weight loss programs

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

- Acupuncture - 30 visits/calendar year for disease, injury & chronic pain.
- Bariatric surgery
- Chiropractic care - 30 visits/calendar year.
- Hearing aids - 1 hearing aid per ear/calendar year.
- Fertility treatment: Fertility counseling and assisted reproductive technology treatments up to 4 SMART cycles administered through Progyny. Call 833-404-2011 to register.
- Private-duty nursing

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For more information on your rights to continue coverage, contact the plan at 1-888-982-3862.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/ebsa/healthreform>
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-888-982-3862. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/ebsa/healthreform>
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).
- Additionally, a consumer assistance program can help you file your appeal. Contact <https://www.aetna.com/individuals-families/member-rights-resources/complaints-grievances-appeals.html>

**Does this plan provide Minimum Essential Coverage? Yes.**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet Minimum Value Standards? Yes.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

|                                               |         |
|-----------------------------------------------|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$1,750 |
| ■ <u>Specialist</u> <u>coinsurance</u>        | 20%     |
| ■ Hospital (facility) <u>coinsurance</u>      | 20%     |
| ■ Other <u>coinsurance</u>                    | 20%     |

#### This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
Diagnostic tests (*ultrasounds and blood work*)  
Specialist visit (*anesthesia*)

|                                        |                 |
|----------------------------------------|-----------------|
| <b>Total Example Cost</b>              | <b>\$12,700</b> |
| <b>In this example, Peg would pay:</b> |                 |
| <u>Cost Sharing</u>                    |                 |
| <u>Deductibles</u>                     | \$1,750         |
| <u>Copayments</u>                      | \$10            |
| <u>Coinsurance</u>                     | \$2,000         |
| <u>What isn't covered</u>              |                 |
| Limits or exclusions                   | \$60            |
| <b>The total Peg would pay is</b>      | <b>\$3,820</b>  |

### Managing Joe's Type 2 Diabetes

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

|                                               |         |
|-----------------------------------------------|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$1,750 |
| ■ <u>Specialist</u> <u>coinsurance</u>        | 20%     |
| ■ Hospital (facility) <u>coinsurance</u>      | 20%     |
| ■ Other <u>coinsurance</u>                    | 20%     |

#### This EXAMPLE event includes services like:

Primary care provider office visits (*including disease education*)  
Diagnostic tests (*blood work*)  
Prescription drugs  
Diabetic supplies (*glucose meter*)

|                                        |                |
|----------------------------------------|----------------|
| <b>Total Example Cost</b>              | <b>\$5,600</b> |
| <b>In this example, Joe would pay:</b> |                |
| <u>Cost Sharing</u>                    |                |
| <u>Deductibles</u>                     | \$1,750        |
| <u>Copayments</u>                      | \$600          |
| <u>Coinsurance</u>                     | \$100          |
| <u>What isn't covered</u>              |                |
| Limits or exclusions                   | \$20           |
| <b>The total Joe would pay is</b>      | <b>\$2,470</b> |

### Mia's Simple Fracture

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

|                                               |         |
|-----------------------------------------------|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$1,750 |
| ■ <u>Specialist</u> <u>coinsurance</u>        | 20%     |
| ■ Hospital (facility) <u>coinsurance</u>      | 20%     |
| ■ Other <u>coinsurance</u>                    | 20%     |

#### This EXAMPLE event includes services like:

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

|                                        |                |
|----------------------------------------|----------------|
| <b>Total Example Cost</b>              | <b>\$2,800</b> |
| <b>In this example, Mia would pay:</b> |                |
| <u>Cost Sharing</u>                    |                |
| <u>Deductibles</u>                     | \$1,750        |
| <u>Copayments</u>                      | \$0            |
| <u>Coinsurance</u>                     | \$200          |
| <u>What isn't covered</u>              |                |
| Limits or exclusions                   | \$0            |
| <b>The total Mia would pay is</b>      | <b>\$1,950</b> |

### 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.

TTY: 711

|                                     |                                                                                                                             |
|-------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|
| <b>English -</b>                    | <b>To access language services at no cost to you, call 1-888-982-3862.</b>                                                  |
| Amharic -                           | የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-888-982-3862 ይደውሉ።.                                                                          |
| Arabic -                            | للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-888-982-3862.                                           |
| Armenian -                          | Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-888-982-3862 հեռախոսահամարով:                                 |
| Carolinian<br>(Kapasal Falawasch) - | ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-888-982-3862.                                      |
| Chamorro -                          | Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-888-982-3862.                                             |
| Chinese Traditional -               | 如欲使用免費語言服務，請致電 1-888-982-3862.                                                                                              |
| Cushitic-Oromo -                    | Tajaajiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-888-982-3862.                                                   |
| French -                            | Afin d'accéder aux services langagiers sans frais, composez le 1-888-982-3862.                                              |
| French Creole (Haitian) -           | Pou jwenn sèvis lang gratis, rele 1-888-982-3862.                                                                           |
| German -                            | Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-888-982-3862 an.                                  |
| Greek -                             | Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-888-982-3862. |
| Gujarati -                          | તમારેકોઇ જાતના ખર્ચ[વિના ભાષાની સે વિના ઓની પહોંર માટે, કોલ કરો 1-888-982-3862.                                             |
| Hindi -                             | आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए, 1-888-982-3862 पर कॉल करें।.                                        |
| Hmong -                             | Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-888-982-3862.                                                   |
| Italian -                           | Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-888-982-3862.                            |
| Japanese -                          | 言語サービスを無料でご利用いただくには、 1-888-982-3862 までお電話ください。                                                                              |
| Karen -                             | လၢတၢ်ကမၤန့ၢ်ကိၣ်အတၢ်မၤစၢအတၢ်ဖံးတၢ်မၤတဖၣ်လၢတအိၣ်ဒီးအပူၤလၢကဘၣ်ဟ့ၣ်အိၣ်အဂီၢ်ဘၣ်န့ၣ် ကိး 1-888-982-3862 တက့ၢ်.                  |
| Korean -                            | 무료 언어 서비스를 이용하려면 1-888-982-3862 번으로 전화해 주십시오.                                                                               |
| Laotian -                           | ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-888-982-3862.                                               |
| Mon-Khmer,<br>Cambodian -           | ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-888-982-3862 ។                                 |
| Navajo -                            | T'áá ni nizaad k'éhjí bee níká a'doowoł doo bą́ąh ílínígóó kojí' hólne' 1-888-982-3862.                                     |
| Pennsylvania Dutch -                | Um Schprooch Services zu griege mitaus Koscht, ruff 1-888-982-3862.                                                         |

[illegible]