
 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, www.groupcertificate.humana.com or by calling 1-866-4ASSIST (427-7478). 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 1-866-4ASSIST (427-7478) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$1,000 Individual / \$2,000 Family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. Preventive, Certain Office Visits, <u>Emergency Room Care</u> , <u>Urgent Care</u> , <u>Prescription Drugs</u> and Certain therapies.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$4,500 Individual / \$9,000 Family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>Balance-billing</u> charges, Health care this <u>plan</u> doesn't cover, and Penalties.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.humana.com/directories or call 1-866-4ASSIST (427-7478) for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .

 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
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$30 <u>copay</u> /visit; <u>deductible</u> does not apply	Not covered	Telehealth or telemedicine services <u>Network Provider</u> : No charge; <u>deductible</u> does not apply. <u>Non-Network Provider</u> : Not covered.
	<u>Specialist</u> visit	\$60 <u>copay</u> /visit; <u>deductible</u> does not apply	Not covered	Telehealth or telemedicine services <u>Network Provider</u> : No charge; <u>deductible</u> does not apply. <u>Non-Network Provider</u> : Not covered.
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	Not covered	Cost share may vary based on where service is performed.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	Not covered	Cost share may vary based on where service is performed.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.humana.com/2018-Rx4-EHB .	Level 1 - Lowest cost generic and brand-name drugs	\$10 <u>copay</u> ; <u>deductible</u> does not apply (Retail) \$25 <u>copay</u> ; <u>deductible</u> does not apply (Mail Order)	Not covered (Retail) Not covered (Mail Order)	30 day supply (retail) 90 day supply (mail order) <u>Preauthorization</u> may be required - if not obtained, penalty will be 100% for certain <u>prescription drugs</u> .
	Level 2 - Higher cost generic and brand-name drugs	\$40 <u>copay</u> ; <u>deductible</u> does not apply (Retail) \$100 <u>copay</u> ; <u>deductible</u> does not apply (Mail Order)	Not covered (Retail) Not covered (Mail Order)	
	Level 3 - Generic and brand-name drugs with higher cost than Level 2	\$75 <u>copay</u> ; <u>deductible</u> does not apply (Retail) \$187.50 <u>copay</u> ; <u>deductible</u> does not apply (Mail Order)	Not covered (Retail) Not covered (Mail Order)	
	Level 4 - Highest cost drugs	25% <u>coinsurance</u> ; <u>deductible</u> does not apply (Retail) 25% <u>coinsurance</u> ; <u>deductible</u> does not apply (Mail Order)	Not covered (Retail) Not covered (Mail Order)	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	<u>Specialty drugs</u>	35% <u>coinsurance</u> ; <u>deductible</u> does not apply. 25% <u>coinsurance</u> ; <u>deductible</u> does not apply (Preferred Specialty Pharmacy)	Not covered	30 day supply. <u>Preauthorization</u> may be required - if not obtained, penalty will be 100% for certain <u>prescription drugs</u> .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	None
If you need immediate medical attention	<u>Emergency room care</u>	\$450 <u>copay/visit</u> ; <u>deductible</u> does not apply	\$450 <u>copay/visit</u> ; <u>deductible</u> does not apply	<u>Copay</u> waived if admitted
	<u>Emergency medical transportation</u>	No charge after <u>deductible</u>	No charge after <u>deductible</u>	None
	<u>Urgent care</u>	\$100 <u>copay/visit</u> ; <u>deductible</u> does not apply	\$100 <u>copay/visit</u> ; <u>deductible</u> does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <u>copay/visit</u> ; <u>deductible</u> does not apply	Not covered	None
	Inpatient services	20% <u>coinsurance</u>	Not covered	None
If you are pregnant	Office visits	No charge	Not covered	<u>Cost sharing</u> does not apply to <u>preventive services</u> .
	Childbirth/delivery professional services	20% <u>coinsurance</u>	Not covered	Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply.
	Childbirth/delivery facility services	20% <u>coinsurance</u>	Not covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound)
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	Not covered	None
	<u>Rehabilitation services</u>	Physical, occupational, cognitive, speech and audiology therapies: \$30 <u>copay/visit</u> ; <u>deductible</u> does not apply	Not covered	20 visits each per year for physical, occupational, cognitive, speech, and audiology therapies. 20 visits per year for spinal manipulations and adjustments.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	<u>Habilitation services</u>	Physical, occupational, speech and audiology therapies \$30 <u>copay</u> /visit; <u>deductible</u> does not apply	Not covered	20 visits each per year for physical, occupational, speech, and audiology therapies. 20 visits per year for spinal manipulations and adjustments. For congenital defects and birth abnormalities 20 visits each per year guaranteed to age 6 for physical, occupational and speech therapies.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	Not covered	100 days per year.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not covered	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	<u>Hospice services</u>	20% <u>coinsurance</u>	Not covered	None
If your child needs dental or eye care	Children's eye exam	50% <u>coinsurance</u>	Not covered	1 exam per year until end of the month child turns 19.
	Children's glasses	50% <u>coinsurance</u>	Not covered	1 frame per year and 1 pair of lenses per year until end of the month child turns 19.
	Children's dental check-up	50% <u>coinsurance</u>	Not covered	2 exams per year until end of the month child turns 19.

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.)

- Bariatric Surgery
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- 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, if it is prescribed by a physician
- Chiropractic Care
- Cosmetic Surgery, if to correct a functional impairment
- Dental Care (Adult), if for dental injury of a sound natural tooth
- Hearing Aids, per 5 years to age 19; 1 pair per 36 months age 19 and older
- Infertility Treatment
- Private Duty Nursing
- Routine eye care (Adult), if for an eye exam

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:

- Humana at 1-866-4ASSIST (427-7478)
- For group health coverage 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
- 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.
- 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 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 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:

- Humana, Inc.: www.humana.com or 1-866-4ASSIST (427-7478).
- Department of Labor Employee Benefits Security Administration: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- Department of Regulatory Agencies, Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202-4910, Phone: 303-894-7490 or 800-930-3745, Website: <http://www.dora.state.co.us/insurance>, Email: insurance@dora.state.co.us.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-4ASSIST (427-7478).

-----*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 plan's overall deductible \$1,000
- Specialist copayment \$60
- Hospital (facility) copayment \$0
- Hospital (facility) coinsurance 20%
- Other coinsurance 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*)

Total Example Cost	\$12,800
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$2,300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,460

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$1,000
- Specialist copayment \$60
- Hospital (facility) copayment \$0
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$2,200
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$1,100
The total Joe would pay is	\$3,300

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible \$1,000
- Specialist copayment \$60
- Hospital (facility) copayment \$0
- Hospital (facility) coinsurance 20%
- Other coinsurance 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*)

Total Example Cost	\$1,900
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$700
<u>Copayments</u>	\$800
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,700

Appendix A
Colorado Supplement to the Summary of Benefits and Coverage Form

<i>INSURANCE COMPANY NAME</i>	Humana Health Plan, Inc.
<i>NAME OF PLAN</i>	HumanaHMO 18 Copay
1. Type of Policy	Small Employer Group Policy
2. Type of plan	<p style="text-align: center;">Health maintenance organization (HMO)</p> <p style="text-align: center;">INTERESTED POLICYHOLDERS, CERTIFICATE HOLDERS, AND ENROLLES ARE HEREBY GIVEN NOTICE THAT THIS SMALL GROUP POLICY REQUIRES THAT AN INSURED TRAVEL OUTSIDE OF THE GEOGRAPHIC AREA TO RECEIVE COVERED HEALTH BENEFITS.</p> <p style="text-align: center;">This means if you live or work outside of the service area where this plan is available, you will have to travel into this service area to receive non-emergency covered services. If you have any questions, please call 1-866-4ASSIST (427-7478).</p>
3. Areas of Colorado where plan is available.	<p style="text-align: center;">Plan is available only in the following areas: Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Jefferson, Larimer, Teller, Weld</p> <p>NOTE: The Humana HMOx plan requires the selection of a Primary Care Physician (PCP). If you have elected this plan, please select the Colorado HMOx network option from the drop down menu in the provider search link within Humana.com to review the provider list and choose a PCP for yourself and any eligible dependents.</p>

SUPPLEMENTAL INFORMATION REGARDING BENEFITS

Important Note: The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. It provides additional information meant to supplement the Summary of Benefits of Coverage you have received for this plan. This plan may exclude coverage for certain treatments, diagnoses, or services not specifically noted. Consult the actual policy to determine the exact terms and conditions of coverage.

	Description
<p>4. Annual Deductible Type</p>	<p>EMBEDDED DEDUCTIBLE</p> <p>INDIVIDUAL – The amount that each member of the family must meet prior to claims being paid. Claims will not be paid for any other individual until their individual deductible or the family deductible has been met.</p> <p>FAMILY – The maximum amount that the family will pay for the year. The family deductible can be met by 2 or more individuals.</p>
<p>5. Out-of-Pocket Maximum</p>	<p>(EMBEDDED OUT-OF-POCKET)</p> <p>INDIVIDUAL – The amount that each member of the family must meet prior to claims being paid at 100%. Claims will not be paid at 100% for any other individual until their individual out-of-pocket or the family out-of-pocket has been met.</p> <p>FAMILY – The maximum amount that the family will pay for the year. The family out-of-pocket can be met by 2 or more individuals.</p>
<p>6. What is included in the In-Network Out-of-Pocket Maximum?</p>	<p>Copayment, Deductibles and Coinsurance</p>
<p>7. Is pediatric dental covered by this plan?</p>	<p>Yes, pediatric dental is subject to the medical deductible and out-of-pocket.</p>
<p>8. What cancer screenings are covered?</p>	<p>Preventive endoscopic services, Preventive Colonoscopy, Sigmoidoscopy, Proctosigmoidoscopy, including Colorectal Cancer screening, Mammogram Screening, Pap Smears and Prostate Cancer Screening</p>

USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
9. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes. This does not apply to HMO plans since they do not have out of network coverage.
10. Does the plan have a binding arbitration clause?	No	

Questions: Call 1-866-4ASSIST (427-7478) or visit us at www.humana.com.

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-427-7478 (TTY: 711).

If you are not satisfied with the resolution of your complaint or grievance, contact: Colorado Division of Insurance
Consumer Services, Life and Health Section
1560 Broadway, Suite 850, Denver, CO 80202
Call: 303-894-7490 (in-state, toll-free: 800-930-3745)
Email: dora_insurance@state.co.us

The Network Access Plan, which describes an access plan specific to your network, is available at www.humana.com or by calling our customer service department and requesting a copy.

Discrimination is Against the Law

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Humana Inc. and its subsidiaries provide:

- Free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.
- Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call 1-866-427-7478 or, if you use a TTY, call 711.

If you believe that Humana Inc. and its subsidiaries have 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:

Discrimination Grievances
P.O. Box 14618
Lexington, KY 40512-4618

If you need help filing a grievance, call 1-866-427-7478 or, if you use a TTY, call 711.

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, 800-537-7697 (TDD)

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

Multi-Language Interpreter Services

English: **ATTENTION:** If you do not speak English, language assistance services, free of charge, are available to you. Call
(TTY: 711).

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al
(TTY: 711).

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
(TTY: 711)。

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
(TTY: 711).

한국어 (Korean): 주의 : 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
(TTY: 711) 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
(TTY: 711).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните
(телетайп: 711).

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele
(TTY: 711).

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le
(ATS : 711).

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer
(TTY: 711).

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para
(TTY: 711).

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero
(TTY: 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer:
(TTY: 711).

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。
(TTY : 711) まで、お電話にてご連絡ください。

فارسی (Farsi):

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با
(TTY: 711) تماس بگیرید.

Diné Bizaad (Navajo): Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, koji' hódíílnih
(TTY: 711).

العربية (Arabic):

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم
(رقم هاتف الصم والبكم: 711).