Kansas City

News-Press & Gazette Company : Buy Up Plan

This 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 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, call **888-495-9340.** 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 **www.cciio.cms.gov** or call **888-495-9340** to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network **$600** person/**$1,200** family. Out-of-Network **$600** person/**$1,200** family.	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-Network preventive care services are 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 preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
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 **$3,500** person/**$7,000** family. Out-of-Network **$10,500** person/**$21,000** family.	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 and health care this plan doesn't cover.	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. See **https://www.MyHealthToolkitKC.com/** or call **1-800-810-BLUE (2583)** for a list of network providers.	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 (You will pay the least)	Out-of-Network Provider (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	$25 Copay/ visit; deductible does not apply	40% Coinsurance	Teladoc visits are covered. In-Network allergy injections, dialysis and surgeries are covered with a 20% Coinsurance. In-Network lab/x-rays are covered at No Charge.
	Specialist visit	$50 Copay/ visit; deductible does not apply	40% Coinsurance	Teladoc dermatology and nutrition visits are covered. In-Network allergy injections, dialysis and surgeries are covered with a 20% Coinsurance. In-Network lab/x-rays are covered at No Charge.
	Preventive care/screening/ immunization	No Charge	40% Coinsurance	See www.healthcare.gov for preventive care guidelines. There may be additional benefits available. See your Employer for details. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance	40% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	40% Coinsurance	Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of all charges. In-Network independent testing centers are covered with a $50 Copay.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at member.mysmithrx.com	Generic drugs (Retail)	$12, deductible does not apply	Reimbursed at the Submitted Rate, minus the copay/coinsurance	Retail: up to a 90-day supply Mail order: up to a 90 day supply Specialty medications: up to a 30-day supply You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by SmithRx. Certain drugs may have a preauthorization requirement or may result in a higher cost. Certain preventive medications are covered at no charge. Dispense as written (DAW) provision applies.
	Generic drugs (Mail Order)	$30, deductible does not apply		
	Preferred brand drugs (Retail)	$35, deductible does not apply		
	Preferred brand drugs (Mail Order)	$87.50, deductible does not apply		

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Non-preferred brand drugs (Retail)	$60, deductible does not apply	Reimbursed at the Submitted Rate, minus the copay/coinsurance	
	Non-preferred brand drugs (Mail Order)	$150, deductible does not apply		
	Specialty drugs	$60, deductible does not apply		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	40% Coinsurance	Pre-authorization is required for some outpatient surgeries. Penalty for not obtaining pre-authorization is denial of all charges.
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	None
If you need immediate medical attention	Emergency room care	$250 Copay/ visit then 20% Coinsurance	$250 Copay/ visit then 20% Coinsurance	Copayment will be waived if admitted.
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	None
	Urgent care	$50 Copay/ visit; deductible does not apply	40% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	40% Coinsurance	Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of room and board.
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Mental/behavioral health outpatient services	20% Coinsurance	40% Coinsurance	Teladoc behavioral health visits are covered with a $25 Copay. In-Network office visits are covered with a $25 Copay.
	Substance use disorder outpatient services	20% Coinsurance	40% Coinsurance	
	Mental/behavioral health inpatient services	20% Coinsurance	40% Coinsurance	Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of room and board.
	Substance use disorder inpatient services	20% Coinsurance	40% Coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	$25 Copay/ visit; deductible does not apply	40% Coinsurance	Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of room and board. Copay applies initial office visits only. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	20% Coinsurance	40% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	20% Coinsurance	40% Coinsurance	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	40% Coinsurance	60 visits/benefit year. Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of all charges.
	Rehabilitation services	20% Coinsurance	40% Coinsurance	60 combined visits/benefit year for Occupational Therapy and Physical Therapy. 20 combined visits/benefit year for Speech Therapy and Hearing Therapy.
	Habilitation services	20% Coinsurance	40% Coinsurance	60 combined visits/benefit year for Occupational Therapy and Physical Therapy. 20 combined visits/benefit year for Speech Therapy and Hearing Therapy.
	Skilled nursing care	20% Coinsurance	40% Coinsurance	30 days/benefit year. Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of room and board.
	Durable medical equipment	20% Coinsurance	40% Coinsurance	Purchase or rentals of $500 or more require pre-authorization. Penalty for not obtaining pre-authorization is denial of all charges. Diabetic shoes are limited to 1 pair/benefit year, and inserts are limited to 3 pair/benefit year.
	Hospice services	20% Coinsurance	40% Coinsurance	14 days/episode. Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of room and board for Inpatient services and denial of all charges for all Outpatient services.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	See your Employer for benefit details.
	Children's glasses	Not Covered	Not Covered	See your Employer for benefit details.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Children's dental check-up	Not Covered	Not Covered	See your Employer for benefit details.

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
- Cosmetic Surgery
- Dental Care (Adult)
- Dental Care (Child)
- Hearing Aids
- Long-Term Care
- Routine Eye Care (Adult)
- Routine Eye Care (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
- Chiropractic Care
- Infertility Treatment, $5,000/benefit year
- Non-emergency care when traveling outside the U.S.
- Private-Duty Nursing, if part of pre-authorized home health care

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: The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa. 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 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: 888-495-9340 or visit us at https://www.MyHealthToolkitKC.com/, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa.

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 page.*———————————

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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** **$600**
- **Specialist Copayment** **$50**
- **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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$600
Copayments	$0
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$3,070**

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

- **The plan's overall deductible** **$600**
- **Specialist Copayment** **$50**
- **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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$4,700**

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

- **The plan's overall deductible** **$600**
- **Specialist Copayment** **$50**
- **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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$600
Copayments	$400
Coinsurance	$300
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$1,310**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact:**888-495-9340.**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-832-9686 (TTY: 711) or speak to your provider.

Espanol: ATENCI6N: Si habla espanol, tiene a su disposici6n servicios gratuitos de asistencia linguistica. Tambien estan disponibles de formagratuita ayuda y servicios auxiliares apropiados para proporcionar informaci6n en formatos accesibles. Llame al 1-844-396-0183 (TTY: 711) o hable con su proveedor. (Spanish)

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Tagalog: PAALALA: Kung nagsasalita ka ng Tagalog, available ang mga libreng serbisyo ng tulong sa wika para sa iyo. Available rin nang walang bayad ang mga naaangkop na auxiliary na tulong at serbisyo para magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-844-389-4839 (TTY: 711) o makipag-usap sa iyong provider. (Tagalog)

Portugues do Brasil: ATENC:AO: Se voce fala portugues, hi servi□os gratuitos de assistencia linguistica disponiveis para voce. Assistencia e servi□os auxiliares pr6prios para fomecer informa□oes em formatos acessiveis tambem estao disponiveis gratuitamente. Ligue para 1-844-396-0182 (TTY: 711) ou fate com seu provedor. (Portuguese)

Fran□ais : NOTE : Si vous parlez fran□ais, des services gratuits d'assistance linguistique sont a votre disposition. Des aides et des services auxiliaires appropries pouvant foumir des informations dans des formats accessibles sont egalement disponibles gratuitement. Appelez le 1-844-396-0190 (TTY: 711) ou adressez-vous a votre prestataire. (French)

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Deutsch: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfiigung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfiigung. Rufen Sie unter 1-844-396-0191 (TTY: 711) an oder sprechen Sie mil Ihrem Anbieter. (German)

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Kiswahili MAKINIKA: Ikiwa wewe huzungurnza Kiswahili, rnsaada na hudurna za lugha bila rnalipo unapatikana kwako. Vifaa vya usaidizi vinavyofaa na hudurna bila rnalipo iii kutoa taarifa katika rnifurno inayofikiwa pia inapatikana bila rnalipo. Piga sirnu 1-844-465-1726 (TTY: 711) au zungurnza na rntoa hudurna wako. (Swahili)

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Soornaali FIIRO GAAR AH: Haddaad ku hadasho Soornaali, adeegyo kaalrnada luuqadda ah oo bilaash ah ayaad heli kartaa. Qalab caawinaad iyo adeegyo oo habboon si loogu bixiyo rnacluurnaadka qaabab la adeegsan karo ayaa sidoo kale bilaa lacag heli karaa. Wac 1-844-465-1724 (TTY: 711) arna la hadal bixiyahaaga. (Somali)

ILOCANO PANANGIKASO: No agsasaoka iti Ilocano, magun-odmo dagiti libre a serbisioti tulong iti pagsasao. Libre met laeng a magun-odan dagiti maitutop a katulongan ken serbisio a mangipaay iti impormasion kadagiti ma-akses a pormat. Awagan ti 1-800-832-9686 (TTY: 711) wenno makisarita iti mangipapaay kenka. (Ilocano)

□ mcrmaf: □ <:141$al 4l...7 JIT!IT <t'l<"ij.),$a-5 a-l al¡'141$<lii <>Ifft*C::anr* □ □ □ □ &a'[I 4□il <Tl•<1 ,rlJiJ le.MI ;;rr.r<i,'ffr fm.r jiiiit34':),<ti'1 □ □ □ q-c;.:r c::f.\":□R><li'□ &a'[I 1-844-465-1722 (TTY: 711) IDt:fifiit"□3fl1r.IT□f TT□I (Nepali)

ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama 1'1-844-396-0184 (TTY: 711) o parla con ii tuo fornitore. (Italian)

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□ □ □ I 1-844-465-1713 (TTY: 711) □ <I>i.1□□1!:iff"'Rm2t'ili-l41flli<I "iW! □T□I (Bengali)

Kreyol Ayisyen ATANSYON: Si w pale Kreyol Ayisyen, gen sevis ed aladispozisyon w gratis pou lang ou pale a. Ed ak sevis siplemante apwopriye pou bay enfomasyon nan foma aksesib yo disponib gratis tou. Rele nan 1-844-465-1715 (TTY: 711) oswa pale avekfounise w la. (Haitian Creole)

POLSKI UWAGA: Osoby m6wiqce po polsku mogq skorzystac z bezptatnej pomocy ililzykowej. Dodatkowe pomoce i ustugi zapewniajqce informacje w dostli:pnych formatach Sq r6wniez dostli:pne bezplatnie. Zadzwori pod numer 1-844-396-0186 (TTY: 711) lub porozmawiaj ze swoim dostawcq, (Polish)

aexirn

,;:r,o.JQ"c00: !nm aexirn *$gtsa,* !:b!ii e,,w6 zyo)o c0;':tcili 1Jo.Jexi @oo:i2J"t\J6 e,otr"O)). eiiY's;:i'i0 0cilil'ie:i *-:::rlJ"it!5e:i6 c0$w"lJ":::::J-;i* @ooowG":::::Js 6M c0;':tcili□ c0;':teiiY'exi illBcili:i 1Jo.Jexi &G" e,w6o!T' @o6:i2J"t\J6 e,,otr"O)). 1-800-832-9686 (TTY: 711)§ *S"O* 0cilio6 °e30" !:b Ltr'0_60S $q"6o6. (Telugu)

Lus Hmoob

LUS CEEV TSHWJ XEEB: Yog hais tias koj hais Lus Hmoob muaj cov kev pab cuam txhais lus pub dawb rau koj. Cov kev pab thiab cov kev pab cuam ntxiv uas tsim nyog txhawm rau m uab lus qhia paub ua cov horn ntaub ntawv uas tuaj yeem nkag cuag tau rau los kuj yeej tseem m uaj pab dawb tsis xam tus nqi dab tsi ib yam nkaus. Hu rau 1 844-465-1717 (TTY: 711) los sis sib tham nrog koj tus kws m uab kev saib xyuas kho mob. (Hmong)

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!;:!-l:'lffIJ□[Ut:l!RBI SffiBS'LHHt/'lruffi ogrutLULCil I:IJCil s AffiGJFiCil stS1CTJl'iAFif'it□Cl-l:'lt/'ll1 tun JJWQtS'l 1-844-465-1721 (TTY: 711) yscrn CTJtS1ffl S:i:fFi□rutWJIJUW:i:fFi1 (Khmer)

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I.; *l.,,;,'!*□ U"L.:i (711 :',;";ltiJ-.ti) 1-844-398-6233 „J' I . ;–□JY.'--9-" u!S.,;I_i _i_,b4; *'U"Y-'"'* Jili c.51...c,.J.i _iJ wlc'.)i.bl "-'I) c.5lY. ":-'-"'U. cs,Ui.+ wl..i;. J t.....s.__.;; □ .J_iiJ *)_ii* W U"Y"'J _iJ (Hjc)□,:J.t,;I_i wl..i;. , □ □ *er').,;* _$.i":½-y (Farsi) *..i,;,S* □ J-9"- ,.w.JJJl)

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-u,J• wl.; *c* ,.,_;,;,;i"/13 c\JI l.,; Lil.ft *J.S.*..\l (1-844-465-1725 TTY: 711)-Lll: ""l,fh,,.I wi.cs½/ d....c;. _iJl Jl.i..l wl£.. □ *d c::"' c::}.fiH13* wl.).... Ll!" □fi._)i..u,_i Jli-Lll: ""l,fh,,.I c:,L..i;.□c:.u'\ci '-""\.J wi. *d c::"'* '-;;'\ *J,* 'Lili c?]Y. *y)* '-;;'1 _t1 :u,J *,q,.,J,* (Urdu)

i!"'i'□

1-833-584-1829 (TTY: 711) ,□,, .7□I□□ ,,□ ,,,□ 7:J.Y7'Y11□ 7'1□ IYm ,O□IJ,□□ □j'7D'1D1I I'□ Y'I□IJ,□□)'□ I7□D\!/rn1I o□o,,,,□o ,,□□7'c '1'7'TP1□ n'O□□ -7"□ ,□□ 7:J.Y7'Y11□ I□)□T 0□0'111YO □7"c 7□1□1!' YDO'TIJ1□ ,i!"i'□ un, ,,□:J.'1□ :XJ,Uj□ (Yiddish) .1Yi"11□1□ 1Y"□ D'IJ DiY11Yi□

Deitsch

WICHDICH: Wann du Deitsch schwetzscht, kenne mer dich Schprooch-Hilf griege. Mir kenne dich aa differnti Sadde Hilf griege, wase\'V\Ver as brauchscht fer Information griege, unni as es dich ennich eppes koschde zellt. Call 1-833-584-1829 (TIT: 711) uff odder schwetz mil <lei Provider. (Pennsylvania Dutch)

Ell□VLKCI

nPOIOXH: Eav µLAa,8 8AA□VLKCI, unapxouv 6ta9sotµs□ .Swpsav U1t□p80L8□ UJtO(J"[□pl□□□ 0'[□ cruyKeKpLµsv□ yllwooa. IILmi9svrnL .Swpsav Kmall□lla □o□a□µma Kat U1t□p80L8□ yta napc,x□ JtA□po,popLWV 0'8 µop,ps□. Kallso,8 rn 1-844-465-1714 (TTY: 711) □ ansu9uv9si,8 O'COV napox6 cra□. (Greek)

Oromoo

Afaan Oromoo HUBACHIISA: Yoo Afaan Oromoo dubbattan ta'e, tajaajilloota gargaarsa afaanii bilisaan isiniif ni kennama. Gargaarsoonni fi tajaajilloonni sirrii ta'an namoota dhagahuufi arguun isaan rakkisuuf odeeffannoo dhangii dhaqqabamaa ta'een kennuunis bilisaan niargamu. Gara 1-800-832-9686 (TTY: 711) tti bilbilaa yookiin 4opheessaa keessan haasofsiisaa. (Oromo)

Gagana Samoa

FAAALIGA: Afai e te tautala i le Gagana Samoa, o loo maua fua auaunaga lagolago mo gagana. 0 le a maua fua fo'i mea faalogo, isi faiga tau fesoasoani ma auaunaga talafeagai e tuuina mai ai faamatalaga i auala faigofie ona maua. Viii le 1-800-832-9686 (TTY: 711) pe talanoa i lau fai auaunaga. (Samoan)