



Thrive Together, LLC : Coupe Non-Finance Plan

Coverage For: Individual + Family Plan Type: Standard PPO

 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, call 1-866-777-0624. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance after overall deductible](#), [copayment](#), [deductible](#), [provider](#), or other [underlined terms](#) see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call 1-866-777-0624 to request a copy.

Important Questions	Answers		Why This Matters:
What is the overall deductible ?	Tier 1-3 In-Network Employee \$0 Family \$0	Tier 4 Out-of-Network Employee \$0 Family \$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	Tier 1-3 In-Network Yes.	Tier 4 Out-of-Network Yes.	A copayment may apply. For example, this plan covers certain preventive services without cost-sharing . 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 deductible for specific services.
What is the out-of-pocket limit for this plan ?	Tier 1-3 In-Network Employee \$3,650 Family \$7,300	Tier 4 Out-of-Network Employee \$0 Family \$0	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 limit until the overall family out-of-pocket limit has been met. The out-of-pocket maximums for all networks cross apply.
What is not included in the out-of-pocket limit ?	Premiums , balance billed charges, health care this plan doesn't cover, cost sharing for most out-of-network benefits, and pre-certification penalties.		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 www.MyHealthToolkitKS.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	Tier 1 In-Network	Tier 2 In-Network	Tier 3 In-Network	Tier 4 Out-of-Network	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 copay	\$25 copay	\$40 copay	\$50 copay	None
	Specialist visit	\$35 copay	\$50 copay	\$80 copay	\$100 copay	
	Preventive care/screening/immunization	No Charge	No Charge	No Charge	No Charge	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)	\$80 copay	\$100 copay	\$160 copay	\$190 copay	Diagnostic labs are covered with a \$20 Copay for Tier 1, \$25 Copay for Tier 2, \$40 Copay for Tier 3, and \$50 Copay for Out-of-Network.
	Imaging (CT/PET scans, MRIs)	\$230 copay	\$310 copay	\$520 copay	\$630 copay	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.myhealthtoolkitFL.com	Tier 1 (Generic Drugs)	\$10 copay	\$10 copay	\$10 copay	40% of cost	Retail Pharmacy 1-91 Day Supply. Mail Order Pharmacy 1-91 Day Supply.
	Tier 2 (Preferred Brand)	\$40 copay	\$40 copay	\$40 copay	40% of cost	
	Tier 3 (Non-Preferred Brand)	\$80 copay	\$80 copay	\$80 copay	40% of cost	1-91 day supplies are covered at retail and mail order.
	Tier 4 (Specialty Drugs)	Not Covered	Not Covered	Not Covered	Not Covered	If you or your doctor requests a brand name drug when a generic equivalent exists, you will pay the difference between the non-preferred brand and generic medication.

If you have outpatient	Facility fee (e.g., ambulatory surgery center)	\$810 copay	\$1,080 copay	\$1,820 copay	\$2,180 copay	Varicose vein treatment is limited to \$3,000/benefit year.
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surgery	Physician/surgeon fees	No Charge	No Charge	No Charge	No Charge	None
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Common Medical Event	Services You May Need	Tier 1 In-Network	Tier 2 In-Network	Tier 3 In-Network	Tier 4 Out-of-Network	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	Emergency room care	\$200 copay	\$200 copay	\$200 copay	\$200 copay	None
	Emergency medical transportation	\$200 copay	\$200 copay	\$200 copay	\$200 copay	None
	Urgent care	\$45 copay	\$45 copay	\$45 copay	\$45 copay	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$2,000 copay	\$2,600 copay	\$4,400 copay	\$5,280 copay	Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of room and board.
	Physician/surgeon fees	No Charge	No Charge	No Charge	No Charge	None

Common Medical Event	Services You May Need	Tier 1 In-Network	Tier 2 In-Network	Tier 3 In-Network	Tier 4 Out-of-Network	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$810 copay	\$1,080 copay	\$1,820 copay	\$2,180 copay	Office visits are covered with a \$20 Copay for Tier 1, \$25 Copay for Tier 2, \$40 Copay for Tier 3, and \$50 for Out-of-Network. Pre-authorization for the facility is required. Penalty for not obtaining pre-authorization is denial of room and board.
	Inpatient services	\$2,000 copay	\$2,600 copay	\$4,400 copay	\$5,280 copay	
If you are pregnant	Office visits	\$20 copay	\$25 copay	\$40 copay	\$50 copay	Pre-authorization for the facility is required. Penalty for not obtaining pre-authorization is denial of room and board. Cost sharing does not apply for preventive services . Depending on the type of services, a copayment , coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); facility fee listed includes facility and physician services associated with maternity facility services.
	Childbirth/delivery professional services	No Charge Included in facility fee	No Charge Included in facility fee	No Charge Included in facility fee	No Charge Included in facility fee	
	Childbirth/delivery facility services	\$2,000 copay	\$2,600 copay	\$4,400 copay	\$5,280 copay	

Common Medical Event	Services You May Need	Tier 1 In-Network	Tier 2 In-Network	Tier 3 In-Network	Tier 4 Out-of-Network	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	\$55 copay	\$70 copay	\$120 copay	\$140 copay	100 visits/benefit year. Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of all charges.
	Rehabilitation services	\$35 copay	\$50 copay	\$80 copay	\$100 copay	40 visits/benefit year combined for physical therapy and occupational therapy.
	Habilitation services	\$35 copay	\$50 copay	\$80 copay	\$100 copay	
	Skilled nursing care	\$1,610 copay	\$2,150 copay	\$3,630 copay	\$4,350 copay	120 visits/benefit year. Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of room and board.
	Durable medical equipment	\$115 copay	\$155 copay	\$160 copay	\$320 copay	Pre-authorization is required for purchases or rentals of \$5,000 or more. Penalty for not obtaining pre-authorization is denial of all charges. Wigs are limited \$500/benefit year. Hearing aids are limited to \$2,500/lifetime. Cochlear implants are limited to \$5,000/lifetime.
	Hospice services	\$270 copay	\$360 copay	\$600 copay	\$715 copay	Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of room and board for inpatient and denial of all charges for In-Network Outpatient and all Out-of-Network services.
	Children's eye exam	Not Covered	Not Covered	Not Covered	Not Covered	Please see your Employer for benefit details.

If your child needs dental or eye care	Children's glasses	Not Covered	Not Covered	Not Covered	Not Covered	Please see your Employer for benefit details.

	Children's dental check-up	Not Covered	Not Covered	Not Covered	Not Covered	Please see your Employer for benefit details.
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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](#).)

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| • Cosmetic surgery | • Acupuncture | • Routine foot care |
| • Dental care (Adult) | • Long-term care | • Weight Loss Programs |
| • Dental care (Child) | • Routine eye care (Adult) | • Bariatric surgery |
| | • Routine eye care (Child) | |

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

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| • Chiropractic care, 20 visits/benefit year | • Infertility Treatment, \$10,000/lifetime | • Hearing Aids |
| • Non-emergency care when traveling outside the U.S. | • 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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: Your plan administrator at the phone number listed in your benefit booklet. You may also contact Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 plan's overall deductible	\$0
■ Specialist copay	\$35
■ Hospital (facility) copay	\$2,000
■ Other	\$810

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*)

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$0
■ Specialist copay	\$20
■ Hospital (facility) copay	\$1,400
■ Other	\$450

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*)

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist copay	\$20
■ Hospital (facility) copay	\$1,400
■ Other	\$450

This EXAMPLE event includes services like:

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

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$2,100
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$70
The total Peg would pay is	\$2,170

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$800
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$3,500
The total Joe would pay is	\$4,300

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,400
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$10
The total Mia would pay is	\$1,410

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: www.myhealthtoolkitnc.com

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

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Ki\$wahili MAJ<INika: Ikiwa wewe huwr,gumza t:ñswahili, msaada r-a huduma za lugha bila malipo unapatikana kw,ko. Vifaa vo/a U\$aidizi vinavyofaa na hu,luma bila malipo ñi kuwa taarifa katika mifumo inayofikiwa pia,ñnapatikar-.abila malipo. Pisa \$imu 1-8A4-465-1726 [TTY, 7111) au zu,jum.a r-a mtoa huduma wañro. (Swahilij

i."Ck: "11\ñññi-,l,"ñññ: ꝼ"ñIS,ꝼ huñTPññññ 2,ññ: Mñ/"A'-f,)1,ñA:Cñlññññ: <ñ,;ññ flñ.ft.ñꝼꝼC)ññ- ñl."ñꝼ<.1"ñ +ññññU)- ñññññ ꝼ7ñj1>J-ñ,,- ꝼññññ-H 'ñññ.JJ, O)ꝼ,e,ñññ: nꝼMI <ññC 1-844""6H592 (TTY: 711) £,e,a:>k IDf.9" ñññññ>.. ñt&Q"ññ,ññññ" (Amharic)

5oomoali FñIRO GAARAH; 1-1:, daad ku hadosho Soomaali, adeeꝼro koa11111;:d>luuQodda oh oo biloash ah ay:,ad t, li la rt.lo. Clolab caawirioad ,,,o adeegv,,; oo habbQori si looꝼu biꝼiyo macluumaadk,,; ꝼab;bla ad eꝼari koro, araa sidoo k.ale bilaa lacag heli k.araa. Wac 1-8ꝼ4-16ꝼ172'1 (TTY: 711) ama la hadal bixivahaaga. (Somali)

IIOCANO PANANGIKA50: Na agsasaoka iti llocaoo, magun-odmo dagiti libre a serbisio li tulong ññ pag,sasaa. Libre met laeng a magur>-odan dagiti mailulap a k.at.ulongan ken serbisia a mangipaav ññ impormasian ladagiti ma-akse, a pormat. Awagan ti 1-80D-B-12-96B6 (TTY: 7111 wenno makisarita iti mangipapaya kenk.a. (Ilacana)

नेपाली सावधान: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि दैनिक शुल्क आदयक सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढोँचाहरूमा जानकारी प्रिन्ट गर्न उपयुक्त सहायता र सेवाहरू पढ्न दैनिक शुल्क उपलब्ध छन्। 1-844-465-1722 (TTY: 711) मा फोन नुनहोस्वा आफ्नो प्रायकसुँ कु रा नुनहोस्। (Nepali)

ATTENZIONE: e p,ri italiano, sono disponibili ;er,i di ;,;tenz;;lr,s1.1i;i"" gr.wili.S,,r,, inoltre ;;ponibili gr;ruitamerile.u.;ili e;;er;i ;,1,1siliari ode111,1;,li per fomire inform* ioni in form;,ti ac,e;;;ibili, Ct>i,ma l'l-844-396-01&4 (TTY: 711.o ll*r!• wn ii luo forritore. (Italian)

,m.;n
□□Noli:ir'ti?il"ƒ"ƒA□□□□□□"RT;{ISRJ□□ mnmm□'@"1"Ji"li□□ 'llllllll>|>|Plf wCERJ□□□□□□ -3 □@□mCT!!'l
l-844-465-1713(TT, 711)□□ '!!l'=iJ;lf□□>il-<i-<iffi"j Silr'JWll"<PF!! !Bengal)

Krevol Ayisyen ATANI'SYON:Si iv pale Kreyol Avisyen, gen,e,,is eel olodispozisvon iv gr.ti,pou lanEou pale. Eel ak sevi, siplemante apwoprive po1J b,iyenform.isyoo an fcm. ak>esib.vo clisponib gr.itis tou, Rele nan 1-844-465-1715 (TTY: 711) o;;w,,p;le ;ivek iounis.ew la, (H<>iti;;ro Creole)

POLSKI UWAGA: o.oby mowi□ce po pDlsku mag,i skorzyrat z bezpłatnej pDmacy j□yl;awej. Dodatkowe pomaDa i usługi zapewniaj,iDa inlarmacje w da,t!;pnyc:h |01matach "I rowniei dDst□pne bezpłatnie. Zadzwan pod numer 1-1144-396-01116 (TTY: 711) lub pDnrmawiaj ze swaim dostaw□. (Polish)

de.),)fu
o'5c,ri5o; lli& ec:))1\1□<!'.-3.!:!Jw Q"we □ □;;,<@□;):) eOQ.IW□□oer@. o:5r"!;J,-, oiJMo □□61!;lc:5' ;;;,□o-r;l;; eo□□□;,,□□1vr'5 ;;;,;;,o;;,e: r'..1;□;.'.,,;Ocful □o'5c:)) S'I'cr
a,;)□QIT' @oc:\Jzrt.n6 eob-OD, 1-800-832-%86 (TTY: 711)il s-6 adJo& eJCT' f:n L&r□Ci58 □□Oe..(Telugu)

Lus Hmoob
LUSCEEV TSHWJ XEES: Yog hais tias koj hais lus Hmoob muaj COY keY pab cuam tl(hais lus pub dawb rau koj. Cov kev pab thiab cov k;;y pab cuam ntxiv uas tsim r'lyog txhawm rau muab lus qhia, paub ua co11 hom ntaub ntawv uas tuaj □m nkag cuag tau rau los kuj yeej tseem muaj pab dawb lsis xam tus nqi dab lsi ib yam nkaus. Hu rau 1-844-465-1717 {TTY: 711) los sis sib tham nrog koj tus kws muab kev saib ryuas kho mob.,(Hmong)

l@T<D
W,fl?i□: □□□"ITTre<J. 3T□get□□llij'fe"3r□□□<Jnl□□Ri3'□1.J51i'i'<f<fc'i□□□□J'fUn})8□□□MJ□□<J?il 1-B44-465-1723

(TTY: 711l "3qTg <raip□ □ i'E'55<1'ai IPun abl)

.fiMt!;llr_>!;IUH"ff\!□AC:P! rii, TI-JMBiur;ilr;sunrn- FnAfllfp lwh'i;cl!'!m-ffMPil'iifri□i'i'n EwLi,nu!;l□l cl!'!m- ii;ci1wnr;l;li-'l rui;npNl□wd r.r1,111,IJ !j:cJffii□rut'i"l,11i;;'!li,ism,r□i;i ruffiu□rutLULt;HlIQ i;;
□Hiul"lc;|E|□CT'P"i;i□Mij;li;ii:ITtm 11fi□i□W:JlIT 1-844-465-1721 (TTY: 711) lJ.□ttrWIS'i'fl l1:tf l"□nJ1N"iIUttl'i1 (Khmer)

_____1..ii□1,,.l,;\$.: vl..i(711 :□) 1-844-398-6233 , _J,,;□-□ ,-"_J.(iJ _;lo.._.._..J,lJ _i,,,Jl,i _;□W,l• J _;l,l,,_.._i..... = J 1,,□□ -'..J'')) W .._.._.._J,j□□ ..,Jl...l,; = •□ □ ,,,;:1• _ti _.._.. (f•rsi) ..>tli□

(Unlu)*..!!!..fo□.:="";£,rOd l,,□JS□ 1-844-465-1725TIY: 7Il}Ji,,□□....□.....;J, ..1;;J,.,,,_.....□ ,f ,df.□J,□J,.,,,□,);,..fa,;;,_Ji'"· ,,,J;f;i = □□1.,i..J.....;l...f,;;i f, d).ll.JJ □ P"-"",,,,"^{....d}

l'l0 o-n,,9□ J-833-584-1829 (ITY: 71I) 10l, ,;l(Jgi-110 ,,,o ""mU1N ,,,□l,111111-"IN□'NO 9J'U""OI• l" -□o,NlU'N (i9Clllii.u: ogc•n,1,c, *J'i□' □'i'R ln'C..□g ,7"N,1,0 'JlH'V111{ llJY109C'ml'C)□:1 7N""oll!l 9UC'l'l01□,l'i"TN]l-r!.., i•N l□ :lll}l;((Yiddi5fi) ,-c,-,>n1'-e -C-ŋ

Dcitwh
WICHDICH: W•llll di, Deitsd1 cbwe11:sc□t. kenne m.er dieb Schproocl:J-Hilf grkgo. Mir keOJJe di ch** diffcmti S•dde Hilf gricge, •V11scwwer 115 br:auc lit rcr Information gri cge,,mni *s cs dkh CJ111ich eppes toschdc zellt. all 1-8:n-S84-1S29 (TIY: 711) uffoddcr schwelZ nnl dci Provide.r, (l'enn,ylvaniaDutcli)

EM□VllO.
nP0IOXH: Eav pdcicuc ElJ,lJVLKli, Lmap□ouv 6LC10emp.a; Sw□av UTll]□OLEs UITDfllPLQ<; crm m1v+++pLph.i1] vl.wooa..11.,aml,vmt OWl)ECIV ..,□)..□01J9,;μ<rTll KJl UTllJ>EOLE, VLO""P"llii MlpD,t,□□LL,)V OE npoof,oo,μEc; pui<J,-a,;. Kmau ,o 1-844-465-1714 (TTY: 711),; arc□u9u□El1frra atDv n@□6 ao,. (Greek)

Oromoo
J.lfaan Oromoo HUeACHiISA l'oo Maan Oromoo dubbanan ta'e, tajaaJilloolagargaar:sa afaanll blllsaan l□Inlif nl kennama, Gargaarsoonnl fl laJaaJillloonnll slrrll ta'an namooia dlla,lahuufi arguun □aan mkklisu fooeeflannoo dhangll dhaq.sqabamaa ta-□nkennuunls bilisaan nlargamu. Gam 1-800.8..□2-9686 (TTY: 711) tll blllblaa \00klin qop□ssaa keoossan haasofsilsaa. (Oromo)

<Jilg;na 5iimw
FAAAUGA: Afai e te tautala i le G.a.gana Samoa, o loo maua fua auauna,ga lagolago mo ,ga,gana .0 le a maua fu.a fdi mea faalo,go, □i faiga tau (e.soasoani m.a.auaunaga talafeag.ai e tuuina m.ai ai faama:talag.ai auala faigofie ona maua_ Vili le li-800-832-9'686 tm: 711) □ talanoa l'au tai auaunaga.,[Samoa)