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

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>In-Network: EE Only $3,000; EE+ Family $6,000. Out-of-Network: EE Only $4,000; EE+ Family $8,000.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. In-network preventive care is covered before you meet your deductible.</td>
<td>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></td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>In-Network: EE Only $5,000; EE+ Family: Individual $6,750/ Family $10,000. Out-of-Network: EE Only $6,000; EE+ Family: Individual $6,000/ Family $12,000.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums, balance-billing charges, penalties for failure to obtain pre-authorization for services &amp; health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out–of–pocket limit.</td>
</tr>
<tr>
<td><strong>Will you pay less if you use a network provider?</strong></td>
<td>Yes. See <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-888-982-3862 for a list of in-network providers.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Do you need a referral to see a specialist?</strong></td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>40% coinsurance</td>
<td>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.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>Copay/prescription: 20% (retail &amp; mail order)</td>
<td>Not covered</td>
<td>Covers 31 day supply (retail), 32-90 day supply (mail order). Includes contraceptive drugs &amp; devices obtainable from a pharmacy, oral &amp; injectable fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-network. Maintenance drugs- after two retail fills, members are required to fill a 90-day supply at CVS Caremark® Mail Service Pharmacy or CVS Pharmacy.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>Copay/prescription: 20% (retail &amp; mail order)</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>Copay/prescription: 20% (retail &amp; mail order)</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Applicable cost as noted above for generic or brand drugs</td>
<td>Not covered</td>
<td>All prescriptions must be filled through the Aetna Specialty Pharmacy Network. Precertification required for coverage.</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>40% coinsurance for out-of-network non-emergency use.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>40% coinsurance for out-of-network non-emergency transport.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>------------------</td>
<td>-----------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Penalty of $400 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Outpatient services</td>
<td>Office &amp; other outpatient services: 20% coinsurance</td>
<td>Office &amp; other outpatient services: 40% coinsurance</td>
<td>Penalty of $400 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Inpatient services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td>Office visits</td>
<td>No charge</td>
<td>40% coinsurance</td>
<td>Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of $400 for failure to obtain pre-authorization for out-of-network care may apply.</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>60 visits/calendar year combined with private-duty nursing. Penalty of $400 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Home health care</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>30 visits/calendar year for Speech &amp; Occupational Therapy, 120 visits/calendar year for Physical Therapy.</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Rehabilitation services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Habilitation services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>120 days/calendar year. Penalty of $400 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Penalty of $400 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Hospice services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td>Children's eye exam</td>
<td>No charge</td>
<td>40% coinsurance</td>
<td>1 routine eye exam/24 months.</td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td>Children's glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered.</td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td>Children's dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered.</td>
</tr>
</tbody>
</table>
### 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.)

<table>
<thead>
<tr>
<th>Excluded Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Bariatric surgery</td>
</tr>
<tr>
<td>- Cosmetic surgery</td>
</tr>
<tr>
<td>- Dental care (Adult &amp; Child)</td>
</tr>
<tr>
<td>- Glasses (Child)</td>
</tr>
<tr>
<td>- Long-term care</td>
</tr>
<tr>
<td>- Non-emergency care when traveling outside the U.S.</td>
</tr>
<tr>
<td>- Routine foot care</td>
</tr>
<tr>
<td>- Weight loss programs - Except for required preventive services.</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Acupuncture - Limited to disease, injury &amp; chronic pain.</td>
</tr>
<tr>
<td>- Chiropractic care - 30 visits/calendar year.</td>
</tr>
<tr>
<td>- Hearing aids - 1 hearing aid to $5,000 maximum per ear/3 years.</td>
</tr>
<tr>
<td>- Infertility treatment - For more information &amp; exceptions, see policy document provided by your employer or call the number on your ID card.</td>
</tr>
<tr>
<td>- Private-duty nursing - Included as part of home health care.</td>
</tr>
<tr>
<td>- Routine eye care (Adult) - 1 routine eye exam/24 months.</td>
</tr>
</tbody>
</table>

### 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](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:
• Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number 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.
• Additionally, a consumer assistance program can help you file your appeal. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

**Does this 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**: $3,000
- **Specialist coinsurance**: 20%
- **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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$3,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,700</td>
</tr>
</tbody>
</table>

**What isn't covered**
- Limits or exclusions: $60

**The total Peg would pay is**: $4,760

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

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

- **The plan's overall deductible**: $3,000
- **Specialist coinsurance**: 20%
- **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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$3,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$500</td>
</tr>
</tbody>
</table>

**What isn't covered**
- Limits or exclusions: $20

**The total Joe would pay is**: $3,520

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

- **The plan's overall deductible**: $3,000
- **Specialist coinsurance**: 20%
- **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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$2,800</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn't covered**
- Limits or exclusions: $0

**The total Mia would pay is**: $2,800
Assistive Technology
Persons using assistive technology may not be able to fully access the following information. For assistance, please call 866-393-0002.

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

Non-Discrimination
Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates.
TTY: 711

**Language Assistance:**

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

Albanian - Për asistencën e gjuhës shtëpisë telefononi falas në 1-888-982-3862.

Amharic - እንግルー ኤሮን መ እንግራሮ ከ 1-888-982-3862 ያለ ዓ.ዕ.ሮ.

Arabic - 1-888-982-3862

Armenian - Նիշատք գումարիչները պաշտպանում (հայերեն) զատկի 1-888-982-3862 անկուսիք զանգ:

Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya.

Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-888-982-3862 ku busa

Bengali-Bangla - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-888-982-3862-তে কল করুন।

Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-982-3862 nga walay bayad.

Burmese - 1-888-982-3862

Catalan - Per rebre assistència en (català), truqui al número gratuït 1-888-982-3862.

Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-888-982-3862 sin gåstu.

Cherokee - ᎠᏗᏝᏫ ᎣᏫᏝᏔ Oklahoma Tribal (GWV) ᎠᏝᏫᏝᏔ 1-888-982-3862 ᎨᏝᏗ ᎠᏝᏗᏝᏜᎦ ᎠᏝᏗ帙 ᏜᏗᏝhawks.

Chinese - 欲取得繁體中文語言協助，請撥打1-888-982-3862，無需付費。

Choctaw - (Chahta) anumpa ya apela a chi l paya hinla 1-888-982-3862.

Cushite - Gargaarsa afaan Oromiffa hiikuur argachuuf lakkokkofsa bilbilaa 1-888-982-3862 irratti bilisaan bilbilaa.

Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-888-982-3862.

French - Pour une assistance linguistique en français appeler le 1-888-982-3862 sans frais.

French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-982-3862 gratis.

German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-982-3862 an.

Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-982-3862 χωρίς χρέωση.

Gujarati - ગુજરાતિમાં સહાય મળે કોઈ પણ અત્યંત વધુ 1-888-982-3862 પર કોલ કરો.

Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-982-3862.

Maka enyemaka asusyu na Igbo kpọọ 1-888-982-3862 na akwughị ụgwọ ọ bụla

Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-982-3862 nga awan ti bayadanyo.

Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-982-3862.

日本語で援助をご希望の方は、1-888-982-3862 まで無料でお電話ください。

한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862 번으로 전화해 주십시오.

オーリンガルスース対応でのサポートを希望する方は、無料電話番号1-888-982-3862をご利用ください。

を希望する方は、無料の電話番号1-888-982-3862をご利用ください。

Kurdish - 1-888-982-3862

Laotian - 1-888-982-3862

Marathi - 1-888-982-3862

Marshallese - Ohng palien sawas en sou nōw 1-888-982-3862 ni sohte isais.

Mon-Khmer, Cambodian - 1-888-982-3862

Navajo - T'áá shi shizaad k'ehjí bee shiká a'doowol nińizingo Diné k'ehjí koji' t'áá jík'e hólne' 1-888-982-3862

Nepali - 1-888-982-3862 मा फोन गर्नुहोस्।

Nilotic-Dinka - 1-888-982-3862 kecîn aɣöc.

Norwegian - For språkkassistance på norsk, ring 1-888-982-3862 kostnadsfritt.

Panjabi - 1-888-982-3862 'ਤੇ ਮਫ਼ਤ ਕਾਲ ਕਰੋ।


Persian - برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 تماس بگیرید.

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-982-3862.

Portuguese - Para obter assistência linguística em português ligue para o 1-888-982-3862 gratuitamente.

Romanian - Pentru asistenţă lingvistică în româneşte telefonaţi la numărul gratuit 1-888-982-3862.
Russian - Чтобы получить помощь русскоговорящего переводчика, позвоните по бесплатному номеру 1-888-982-3862.

Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-888-982-3862 e aunoa ma se totogi.

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatni broj 1-888-982-3862.

Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-888-982-3862.

Sudanic-Fulfude - Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-888-982-3862. Njodi woo fawaaki on.

Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-888-982-3862 bila malipo.

Syriac - 

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-982-3862 nang walang bayad.

Telugu - షాయంరాలంట ఖర్లకం 1-888-982-3862 కోసం తెలుగు భాష ప్రాంతానికి నరిడి డాను.

Thai - สําหรับความช่วยเหลือทางด้านภาษาเป็นภาษาไทย โทร 1-888-982-3862 ฟรีไม่มีค่าใช้จ่าย.

Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-888-982-3862 o 'ikai hā ōtōngi.

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-888-982-3862 nge esapw kamé ngonuk.

Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödeden 1-888-982-3862.

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-982-3862.

Urdu - 1-888-982-3862

Vietnamese - Đê được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-888-982-3862.

Yiddish - 1-888-982-3862

Yoruba - Fún irànìlọwọ nípa èdè (Yorùbá) pe 1-888-982-3862 lái san owó kankan rárá.