The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.HealthReformPlanSBC.com. 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/.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: EE Only $4,000; EE + Family $8,000. Out-of-Network: EE Only $6,000; EE + Family $12,000. Does not apply to preventive care in-network.	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 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 and telehealth 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 certain 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: EE Only $8,000; EE+ Family $16,000. Out-of-Network: EE Only $12,000; EE+ Family $24,000.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limit until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, penalties for failure to obtain pre-authorization for service, and health care this plan does not 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. Visit www.aetna.com/docfind or call 1-866-925-0353, for a list of In-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	30% coinsurance	40% coinsurance	Deductible applies first Virtual visit – In-Network no member cost share; deductible does not apply.
	Specialist visit	30% coinsurance	40% coinsurance	Deductible applies first Virtual visit – In-Network no member cost share; deductible does not apply.
	Preventive care/screening/immunization	No charge	40% coinsurance	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)	30% coinsurance	40% coinsurance	Deductible applies first
	Imaging (CT/PET scans, MRIs)	30% coinsurance	40% coinsurance	Deductible applies first
If you need drugs to treat your illness or condition **Prescription drug coverage is administered by CVS Caremark** More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	$10 copay 30 day supply $20 copay 90 day supply	Plan pays in-network benefit amount; you are responsible for additional cost	Deductible applies first for non-preventive drugs. No deductible applies for preventive drugs. Pre-authorization may be required for some drugs. Specialty medications are limited to a 30-day fill
	Preferred brand drugs	25% coinsurance ($25 min, $65 max) 30 day supply $70 copay 90 day supply	Plan pays in-network benefit amount; you are responsible for additional cost	Deductible applies first for non-preventive drugs. No deductible applies for preventive drugs. Pre-authorization may be required for some drugs. Specialty medications are limited to a 30-day fill

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	35% coinsurance ($40 min, $120 max) 30 day supply $120 copay 90 day supply	Plan pays in-network benefit amount; you are responsible for additional cost	Deductible applies first for non-preventive drugs. No deductible applies for preventive drugs. Pre-authorization may be required for some drugs. Specialty medications are limited to a 30-day fill
	Specialty drugs	PrudentRx eligible: after deductible is met, $0 when enrolled with PrudentRx. If not enrolled, you pay 30% coinsurance. All other specialty: same cost as retail listed above	Plan pays in-network benefit amount; you are responsible for additional cost	CVS Caremark partners with PrudentRx to help you save money on eligible specialty drugs. If you are taking a medication on the PrudentRx eligible list and do not enroll, the amount you pay out-of-pocket for these medications will not apply toward your out-of-pocket maximum.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	40% coinsurance	Deductible applies first Pre-authorization is required
	Physician/surgeon fees	30% coinsurance	40% coinsurance	Deductible applies first
Select surgery procedures through Aetna/Carrum Center of Excellence	Select eligible procedures (bariatric, cancer, cardiac, MSK, transplants, CAR-T, or gene therapy) by Quality & Effective Care Providers	$500 copayment	Not covered	Deductible applies first Certain surgical procedure bundles are covered at 100% after deductible and copay when received through the Aetna/Carrum Centers of Excellence surgery benefit. Contact Carrum Health at 888-450-7345 or visit carrum.me/COEBundles for more information
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	Deductible applies first; 50% coinsurance for non-emergency use.
	Emergency medical transportation	30% coinsurance	30% coinsurance	Deductible applies first; 50% coinsurance for non-emergency transport.
	Urgent care	30% coinsurance	40% coinsurance	No coverage for non-urgent use

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 have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	40% coinsurance	Deductible applies first; Penalty of $400 (or 20% of allowed amount) for failure to obtain pre-authorization for out-of-network care.
	Physician/surgeon fees	30% coinsurance	40% coinsurance	Deductible applies first
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: 30% coinsurance	Office & other outpatient services: 40% coinsurance	Deductible applies first Virtual visit – In-Network no member cost share; deductible does not apply.
	Inpatient services	30% coinsurance	40% coinsurance	Deductible applies first; Penalty of $400 (or 20% of allowed amount) for failure to obtain pre-authorization for out-of-network care.
If you are pregnant	Office visits	30% coinsurance	40% coinsurance	Deductible applies first except for where cost sharing does not apply for certain preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Penalty of $400 (or 20% of allowed amount) for failure to obtain pre-authorization for out-of-network care may apply.
	Childbirth/delivery professional services	30% coinsurance	40% coinsurance	Cost sharing does not apply for certain preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Penalty of $400 (or 20% of allowed amount) for failure to obtain pre-authorization for out-of-network care may apply.
	Childbirth/delivery facility services	30% coinsurance	40% coinsurance	Cost sharing does not apply for certain preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Penalty of $400 (or 20% of allowed amount) for failure to obtain pre-authorization for out-of-network care may 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)	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	40% coinsurance	Deductible applies first; 180 visits/calendar year. Penalty of $400 (or 20% of allowed amount) for failure to obtain pre-authorization for out-of-network care.
	Rehabilitation services	30% coinsurance	40% coinsurance	Deductible applies first; 60 visits/calendar year for Physical, Occupational & Speech Therapy combined, including outpatient hospital services.
	Habilitation services	30% coinsurance	40% coinsurance	Deductible applies first; includes outpatient hospital services.
	Skilled nursing care	30% coinsurance	40% coinsurance	Deductible applies first; 180 days/calendar year. Penalty of $400 (or 20% of allowed amount) for failure to obtain pre-authorization for out-of-network care.
	Durable medical equipment	30% coinsurance	40% coinsurance	Deductible applies first; Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	30% coinsurance	40% coinsurance	Deductible applies first; Penalty of $400 (or 20% of allowed amount) for failure to obtain pre-authorization for out-of-network care.
If your child needs dental or eye care	Children's eye exam	30% coinsurance	Not covered	1 routine eye exam/24 months.
	Children's glasses	Not covered	Not covered	Covered under vision plan, if elected.
	Children's dental check-up	Not covered	Not covered	Covered under dental plan, if elected.

Excluded Services & Other Covered Services:

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

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses
- GLP-1 drugs (except to treat diagnosed Type-2 Diabetes)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs (except qualified preventive services)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Bariatric surgery • Chiropractic care - 15 visits/calendar year • Hearing aids - $3,000 maximum/3 years	• Infertility treatment - Artificial insemination & ovulation induction & Advanced reproductive technology & Infertility Rx: 3 Smart Cycles/lifetime through Progyny	• Private-duty nursing - 70 - 8 hour shifts per calendar year • Routine eye care (Adult) - 1 routine eye exam/24 months for in-network only

Pre-Authorization:

Some procedures, tests and prescriptions need prior approval to be sure they're right for you. In these cases, your doctor can submit a request on your behalf to get that approval.	
Medical Service: Contact Aetna A1A at 866- 925-0353.	**Prescription:** Contact CVS Caremark's Prior Authorization Department at 800-294-5979.

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 Aetna at 1-866-925-0353
- 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 : https://www.dol.gov/agencies/ebsa
- 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:

- Aetna at 1-866-925-0353
- 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 https://www.dol.gov/agencies/ebsa
- 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	$4,000
Specialist coinsurance	30%
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	$4,000
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,060**

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

The plan's overall deductible	$4,000
Specialist coinsurance	30%
Primary care coinsurance	30%
Other coinsurance	30%

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	$4,000
Copayments	$0
Coinsurance	$400
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$4,420**

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

The plan's overall deductible	$4,000
Specialist coinsurance	30%
Emergency room coinsurance	30%
Other coinsurance	30%

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	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-982-3862.

Smartphone or Tablet

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

Non-Discrimination

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

Aetna provides 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: PO Box 24030 Fresno, CA 93779),

1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705),

Email: 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 (Aetna).

TTY: 711

Language Assistance:

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

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-888-982-3862.
Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-888-982-3862 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-888-982-3862
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-888-982-3862 առանց գնով:
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-Bangala -	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 -	ဌေးကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-888-982-3862ကို ခေါ်ဆိုပါ။
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 -	ᎾᏍᎩᎾ ᎦᏬᏂᎯᏍᏗ ᏗᏂᏍᎦᏴᏍᎩ ᎾᏂᎢ (GWY) ᏧᏏᎳᏎᏊ 1-888-982-3862 ᎤᎾᎢ Ꮭ ᎪᎢᏍᏗ ᏧEGᏢᏗ ᏂᏲᎡᎾ.
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 I paya hinla 1-888-982-3862.
Cushite -	Gargaarsa afaan Oromiffa hiikuu 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 -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-888-982-3862 પર કૉલ કરો.
Hawaiian -	No ke kōkua ma ka ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-888-982-3862. Kāki ʻole ʻia kēia kōkua nei.

Hindi - हिन्दी में भाषा सहायता के लिए, 1-888-982-3862 पर मुफ्त कॉल करें।

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

Ibo - Maka enyemaka asụsụ na Igbo kpọọ 1-888-982-3862 na akwụghị ụgwọ ọ bụla

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

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

Japanese - 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。

Karen - လၢတၢ်မၤစၢၤတၢ်ကတိၤကျိာ်အဂီၢ် ကျိာ် ကိး 1-888-982-3862 တၢအိာ်ဒီးတၢ်လၢာ်ဘျုာ်လၢာ်စုဟဉ်

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

Kru-Bassa - Bɛ́m̀ké gbo-kpá-kpá dyé pídyi dé Bǎsɔ́ɔ̀-wùdùǔn wɛ̃ɛ, dá 1-888-982-3862

Kurdish - برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 به خۆرایی پەیوەندی بکەن.

Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-888-982-3862 ໂດຍບໍ່ເສຍຄ່າໂທ.

Marathi - तीलभाषा (मराठी) सहाय्यासाठी 1-888-982-3862 क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.

Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-888-982-3862 ilo ejjelok wōnān.

Micronesian - Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-982-3862 ni sohte isais.

Mon-Khmer, Cambodian - សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-888-982-3862 ដោយឥតគិតថ្លៃ។

Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-888-982-3862

Nepali - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-888-982-3862 मा फोन गर्नुहोस् ।

Nilotic-Dinka - Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-888-982-3862 kecïn aɣöc.

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

Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-982-3862 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-888-982-3862 aa. Es Aaruf koschtet nix.

Persian - برای راهنمایی به زبان فارسی با شمارە 1-888-982-3862 بدون هیچ هزینه ای تماس بگیرید. انگلیسی

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 русскоязычного 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 besplatan 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 ɗoo 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 - 1-888-982-3862

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

Telugu - భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-888-982-3862 కు కాల్ చేయండి. (తెలుగు)

Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย 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 ödemeden 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 - Để 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 ìrànlọwọ nípa èdè (Yorùbá) pe 1-888-982-3862 lái san owó kankan rárá.