## Summary of Benefits and Coverage: What this Plan Covers & What it Costs

### Important Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>Network: Individual $0 / Family $0. Out-of-Network: Individual $250 / Family $750. Does not apply to prescription drugs and emergency care.</td>
<td>You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.</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, but see the chart starting on page 2 for other costs for services this plan covers.</td>
</tr>
<tr>
<td><strong>Is there an out-of-pocket limit on my expenses?</strong></td>
<td>Yes. Network: Individual $6,350 / Family $12,700. Out-of-Network: Individual $1,000 / Family $3,000.</td>
<td>The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums, balance-billed charges, penalties for failure to obtain pre-authorization for service, and health care this plan does not cover.</td>
<td>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td><strong>Is there an overall annual limit on what the plan pays?</strong></td>
<td>No.</td>
<td>The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.</td>
</tr>
<tr>
<td><strong>Does this plan use a network of providers?</strong></td>
<td>Yes. See <a href="http://www.aetna.com">www.aetna.com</a> or call 1-888-982-3862 for a list of network providers.</td>
<td>If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.</td>
</tr>
<tr>
<td><strong>Do I need a referral to see a specialist?</strong></td>
<td>No.</td>
<td>You can see the specialist you choose without permission from this plan.</td>
</tr>
<tr>
<td><strong>Are there services this plan doesn't cover?</strong></td>
<td>Yes.</td>
<td>Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services.</td>
</tr>
</tbody>
</table>

**Coverage for:** Individual + Family  | **Plan Type:** POS

**Questions:** Call 1-888-982-3862 or visit us at www.HealthReformPlanSBC.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.HealthReformPlanSBC.com or call 1-888-982-3862 to request a copy.
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<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Network Provider</th>
<th>Your Cost If You Use an Out–of–Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>$10 copay/visit</td>
<td>30% coinsurance</td>
<td>Includes Internist, General Physician, Family Practitioner or Pediatrician.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$20 copay/visit</td>
<td>30% coinsurance</td>
<td>_<em><strong><strong><strong><strong><strong><strong><strong><strong>none</strong></strong></strong></strong></strong></strong></strong></strong></em></td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>$20 copay/visit</td>
<td>30% coinsurance</td>
<td>_<em><strong><strong><strong><strong><strong><strong><strong><strong>none</strong></strong></strong></strong></strong></strong></strong></strong></em></td>
</tr>
<tr>
<td></td>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>30% coinsurance, except routine physicals &amp; immunizations not covered</td>
<td>Age and frequency schedules may apply.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td>_<em><strong><strong><strong><strong><strong><strong><strong><strong>none</strong></strong></strong></strong></strong></strong></strong></strong></em></td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$50 copay/visit, except no charge if performed in a Preferred Complex Radiology Network</td>
<td>30% coinsurance</td>
<td>_<em><strong><strong><strong><strong><strong><strong><strong><strong>none</strong></strong></strong></strong></strong></strong></strong></strong></em></td>
</tr>
</tbody>
</table>

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**Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.

**Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.

The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)

This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.
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<table>
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<tr>
<th>Common Medical Event</th>
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<th>Your Cost If You Use an Out-of-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>Copay/prescription: $5 (retail), $10 (mail order)</td>
<td>20% coinsurance (retail)</td>
<td>Covers 31 day supply (retail), 32-100 day supply (mail order). Includes contraceptive drugs &amp; devices obtainable from a pharmacy, oral &amp; injectable fertility drugs. No charge for formulary generic FDA-approved women's contraceptives in-network. Review your formulary for prescriptions requiring precertification or step therapy for coverage. Your cost will be higher for choosing Brand over Generics unless prescribed. Dispense as Written.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>Copay/prescription: $20 (retail), $40 (mail order)</td>
<td>20% coinsurance (retail)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>Copay/prescription: $35 (retail), $70 (mail order)</td>
<td>20% coinsurance (retail)</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>First prescription must be filled at a participating retail pharmacy or Aetna Specialty Pharmacy Networks. Subsequent fills must be through Aetna Specialty Pharmacy Networks.</td>
</tr>
<tr>
<td>Premier Plus Three Tier Open Formulary</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td>_<strong><strong><strong><strong>none</strong></strong></strong></strong></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td>_<strong><strong><strong><strong>none</strong></strong></strong></strong></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>$100 copay/visit</td>
<td>$100 copay/visit</td>
<td>No coverage for non-emergency use.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No charge</td>
<td>No charge</td>
<td>30% coinsurance for non-emergency transport for out-of-network.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$25 copay/visit</td>
<td>30% coinsurance</td>
<td>No coverage for non-urgent use.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td>Pre-authorization required for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td>_<strong><strong><strong><strong>none</strong></strong></strong></strong></td>
</tr>
</tbody>
</table>

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<table>
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<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Network Provider</th>
<th>Your Cost If You Use an Out-of-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>$10 copay/visit</td>
<td>30% coinsurance</td>
<td>Pre-authorization required for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>$10 copay/visit</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td>Pre-authorization required for out-of-network care.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td>Includes outpatient postnatal care. Pre-authorization required for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td>Coverage is limited to 120 visits per calendar year. Pre-authorization required for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$20 copay/visit</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td>Coverage is limited to 90 days per calendar year. Pre-authorization required for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td>Pre-authorization required for out-of-network care.</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Eye exam</td>
<td>$20 copay/visit</td>
<td>30% coinsurance</td>
<td>Coverage is limited to 1 routine eye exam per 12 months.</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered.</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered.</td>
</tr>
</tbody>
</table>

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Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Does NOT Cover</th>
<th>Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acupuncture</td>
<td>• Infertility treatment - Coverage is limited to the diagnosis and treatment of underlying medical condition, artificial insemination &amp; ovulation induction limited to $20,000 and 4 separate attempts per lifetime.</td>
</tr>
<tr>
<td>• Cosmetic surgery</td>
<td>• Private-duty nursing</td>
</tr>
<tr>
<td>• Dental care (Adult &amp; Child)</td>
<td>• Routine eye care (Adult) - Coverage is limited to 1 routine eye exam per 12 months.</td>
</tr>
<tr>
<td>• Glasses (Child)</td>
<td>• Hearing aids - Coverage is limited to 1 hearing aid per ear per 24 months for children up to age 12.</td>
</tr>
<tr>
<td>• Habilitation services</td>
<td>• Bariatric surgery</td>
</tr>
<tr>
<td>• Long-term care</td>
<td>• Chiropractic care</td>
</tr>
<tr>
<td>• Non-emergency care when traveling outside the U.S.</td>
<td>• Hearing aids - Coverage is limited to 1 hearing aid per ear per 24 months for children up to age 12.</td>
</tr>
<tr>
<td>• Routine foot care</td>
<td>• Hearing aids - Coverage is limited to 1 hearing aid per ear per 24 months for children up to age 12.</td>
</tr>
<tr>
<td>• Weight loss programs - Except for required preventive services.</td>
<td>• Bariatric surgery</td>
</tr>
</tbody>
</table>

Your Rights to Continue Coverage:
If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-982-3862. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-644-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact us by calling the toll free number on your Medical ID Card. If your group health plan is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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

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Coverage for: Individual + Family | Plan Type: POS

**Does this Coverage Provide Minimum Essential Coverage?**
The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". This plan or policy does provide minimum essential coverage.

**Does this Coverage Meet Minimum Value Standard?**
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

<table>
<thead>
<tr>
<th>Having a baby (normal delivery)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amount owed to providers:</strong></td>
</tr>
<tr>
<td><strong>Plan pays:</strong></td>
</tr>
<tr>
<td><strong>Patient pays:</strong></td>
</tr>
</tbody>
</table>

**Sample care costs:**
- Hospital charges (mother) $2,700
- Routine obstetric care $2,100
- Hospital charges (baby) $900
- Anesthesia $900
- Laboratory tests $500
- Prescriptions $200
- Radiology $200
- Vaccines, other preventive $40

**Total** $7,540

**Patient pays:**
- Deductibles $0
- Copays $10
- Coinsurance $0
- Limits or exclusions $200

**Total** $210

<table>
<thead>
<tr>
<th>Managing type 2 diabetes (routine maintenance of a well-controlled condition)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amount owed to providers:</strong></td>
</tr>
<tr>
<td><strong>Plan pays:</strong></td>
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<tr>
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</table>

**Sample care costs:**
- Prescriptions $2,900
- Medical Equipment and Supplies $1,300
- Office Visits and Procedures $700
- Education $300
- Laboratory tests $100
- Vaccines, other preventive $100

**Total** $5,400

**Patient pays:**
- Deductibles $0
- Copays $300
- Coinsurance $0
- Limits or exclusions $80

**Total** $380
Questions and answers about the Coverage Examples:

What do the Coverage Examples show?
For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?
No. Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Can I use Coverage Examples to compare plans?
Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Does the Coverage Example predict my future expenses?
No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Are there other costs I should consider when comparing plans?
Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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**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 on the basis of race, color, national origin, age, disability, or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aetna:
- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 14462, Lexington, KY 40512, 1-800-648-7817, TTY 711, Fax 859-425-3379, CRCoordinator@aetna.com.

California HMO/HNO Members: Civil Rights Coordinator, PO Box 24030 Fresno CA, 93779, 1-800-648-7817, TTY 711, Fax 860-262-7705, CRCoordinator@aetna.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (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 asistencë në gjuhën shqipe telefononi falas në 1-888-982-3862.

**Amharic** - ለምሳሽ ከማ በማማዝ በ 1-888-982-3862 ያለና ይስምኝ ይወገዳ.

**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 numero 1-888-982-3862 ku busa

**Bengali-Bangala** - বাংলা উপস্থাপনা নিয়ে কথিত হবে 1-888-982-3862.

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

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**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** - ᓄᑲᑲᒡ ᓄᑲᑲpluck ᓄᑲᑲpluck ᓄᑲpluck ᓄᑲpluck ᓄpluck 1-888-982-3862 ᓄpluck ᓄpluck ᓄpluck ᓄpluck ᓄpluck ᓄpluck ᓄpluck ᓄpluck ᓄpluck.

**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.

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**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.

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Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-982-3862.
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Pentru asistență lingvistică în română lăsați-l la numărul gratuit 1-888-982-3862.

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

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Fún iranlọwọ nípa èdè (Yorùbá) pe 1-888-982-3862 látí san ówó kankan rará.