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

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

### Important Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>Network: Individual $0 / Family $0.</td>
<td>See the chart starting on page 2 for your costs for the services this plan covers.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</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>Is there an out-of-pocket limit on my expenses?</td>
<td>Yes. Network: Individual $6,350 / Family $12,700.</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>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billed charges, 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>Is there an overall annual limit on what the plan pays?</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>Does this plan use a network of providers?</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>Do I need a referral to see a specialist?</td>
<td>Yes, for in-network specialists.</td>
<td>This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist.</td>
</tr>
<tr>
<td>Are there services this plan doesn't cover?</td>
<td>Yes.</td>
<td>Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services.</td>
</tr>
</tbody>
</table>

### Questions

Call 1-888-982-3862 or visit us at [www.HealthReformPlanSBC.com](http://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](http://www.HealthReformPlanSBC.com) or call 1-888-982-3862 to request a copy.
Summary of Benefits and Coverage: What this Plan Covers & What it Costs

- **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.

<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>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$10 copay/visit</td>
<td>Not covered</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>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>$20 copay/visit</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>Not covered</td>
<td>Age and frequency schedules may apply.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
<td>Not covered</td>
<td></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>Not covered</td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Your Cost If You Use a Network Provider</td>
<td>Your Cost If You Use an Out-of-Network Provider</td>
<td>Limitations &amp; Exceptions</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>--------------------------------</td>
<td>----------------------------------------</td>
<td>-------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<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 after copay/prescription: $5 (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. 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 after copay/prescription: $20 (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 after copay/prescription: $35 (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>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>No charge</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>Not covered</td>
<td></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></td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$20 copay/visit</td>
<td>Not covered</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>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>No charge</td>
<td>Not covered</td>
<td></td>
</tr>
<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>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>No charge</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>$10 copay/visit</td>
<td>Not covered</td>
<td></td>
</tr>
</tbody>
</table>

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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></td>
<td>Substance use disorder inpatient services</td>
<td>No charge</td>
<td>Not covered</td>
<td>______________-none-______________</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>No charge</td>
<td>Not covered</td>
<td>______________-none-______________</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>No charge</td>
<td>Not covered</td>
<td>Includes outpatient postnatal care.</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>Not covered</td>
<td>Coverage is limited to 120 visits per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$20 copay/visit</td>
<td>Not covered</td>
<td>______________-none-______________</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>Not covered</td>
<td>Coverage is limited to 90 days per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>No charge</td>
<td>Not covered</td>
<td>______________-none-______________</td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>No charge</td>
<td>Not covered</td>
<td>______________-none-______________</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Eye exam</td>
<td>$20 copay/visit</td>
<td>Not covered</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>

### Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover**  
(This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs - Except for required preventive services.

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

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.)

- Bariatric surgery
- Chiropractic care
- Hearing aids - Coverage is limited to 1 hearing aid per ear per 24 months for children up to age 12.
- Infertility treatment - Benefit limitations may apply.
- Routine eye care (Adult) - Coverage is limited to 1 routine eye exam per 12 months.
- Private-duty nursing - Coverage is limited to 70 - 8 hour shifts per calendar year.

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 1-866-444-3272 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

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.

Having a baby (normal delivery)

- Amount owed to providers: $7,540
- Plan pays: $7,330
- Patient pays: $210

Sample care costs:

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital charges (mother)</td>
<td>$2,700</td>
</tr>
<tr>
<td>Routine obstetric care</td>
<td>$2,100</td>
</tr>
<tr>
<td>Hospital charges (baby)</td>
<td>$900</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$900</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$500</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$200</td>
</tr>
<tr>
<td>Radiology</td>
<td>$200</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$7,540</strong></td>
</tr>
</tbody>
</table>

Patient pays:

- Deductibles                          | $0      |
- Copays                               | $10     |
- Coinsurance                          | $0      |
- Limits or exclusions                  | $200    |
| **Total**                             | **$210** |

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: $5,400
- Plan pays: $5,020
- Patient pays: $380

Sample care costs:

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$2,900</td>
</tr>
<tr>
<td>Medical Equipment and Supplies</td>
<td>$1,300</td>
</tr>
<tr>
<td>Office Visits and Procedures</td>
<td>$700</td>
</tr>
<tr>
<td>Education</td>
<td>$300</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$100</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$5,400</strong></td>
</tr>
</tbody>
</table>

Patient pays:

- Deductibles                          | $0      |
- Copays                               | $300    |
- Coinsurance                          | $0      |
- Limits or exclusions                  | $80     |
| **Total**                             | **$380** |

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.

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example 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.

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.

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.

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.
**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 - እንቅስቃሴ ስማ መልማት ከ1-888-982-3862 ይችላል እxef-
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 - �� �� �� �� �� �� �� �� �� 1-888-982-3862 �� �� ��
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), ãang 1-888-982-3862 sin ģåstu.
Cherokee - �� �� �� �� �� �� �� �� �� �� �� �� 1-888-982-3862 �� �� �� �� �� �� �� �� �� �� �� ��
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 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 - �� �� �� �� �� �� �� �� �� �� �� �� �� 1-888-982-3862 �� �� �� �� �� �� �� �� �� �� �� ��.

Hindi - अल्पकोटा किया हिन्दी में यह द्वारा संपर्क करें 1-888-982-3862. नए खिचे हिंदी कोटा नहीं।

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

Ibo - Maka enyemaka asusụ na Igbo kpọọ 1-888-982-3862 na akwụghị úgwọ o bula

Ilocano - Para iti tulong ti pagkaisao iti pagkaisao 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 - Be ŋn kē gbo- kpá- kpá dyé pïdyi dé Básóo- wùqùún wëe, dą 1-888-982-3862

Kurdish - 1-888-982-3862

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

Marathi - (1-888-982-3862) 1-888-982-3862

Marxallasse - Ňan bōk jipañ ilo Kajin Majol, kallok 1-888-982-3862 ilo eijelok wônän.

Micronesian- Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 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 ninizingo Diné k'ehjí koji' t'áá jíik'e hólne' 1-888-982-3862

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Nilotic-Dinka - Tën kuony ŋ thok ŋ Thuonjăŋ col 1-888-982-3862 kecĩn avóc.

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

Panjabi - ਪੰਜਾਬੀ ਭਾਸ਼ਾ ਤੇ ਸਹਾਇਤਾ ਲਈ, 1-888-982-3862 ਉੱਤੇ ਫੋਨ ਕਰਨੀ ਚਾਹੀਦੀ ਹੈ।


Persian - برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 گفتگو کنید.

Polish - Aby uzyskać pomoc w języku polskim, zadźwoń bezpłatnie pod numer 1-888-982-3862.
Para obter assistência linguística em português ligue para o 1-888-982-3862 gratuitamente.

Pentru asistență lingvistică în română lăsați telefon pentru gratuit 1-888-982-3862.

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

Za jezičnu pomoć na hrvatskom jeziku pozovite besplatno broj 1-888-982-3862.

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

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

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

Капау ‘oku fiema’u hā tokoni ‘i he lea faka-Tonga telefoni 1-888-982-3862 ‘o ‘ikai hā tōtōngi.

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

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

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

Fún irànìwò nípa èdè (Yorùbá) pe 1-888-982-3862 lái san owó kankan rará.