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>What is the overall deductible?</td>
<td>In-Network: Individual $900 / Family $1,800. Out-of-Network: Individual $2,000 / Family $4,000.</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 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.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Emergency care &amp; prescription drugs; plus in-network office visits &amp; preventive care are 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>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>In-Network: Individual $4,000 / Family $6,850. Out-of-Network: 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>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges, health care this plan doesn’t cover &amp; penalties for failure to obtain pre-authorization for services.</td>
<td>Even though you pay these expenses, they don’t count toward the out–of–pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</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>Do you need a referral to see a specialist?</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>$25 <strong>copay</strong>/visit, deductible doesn't apply</td>
<td>30% <strong>coinsurance</strong></td>
<td>None</td>
</tr>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Specialist visit</td>
<td>$40 <strong>copay</strong>/visit, deductible doesn't apply</td>
<td>30% <strong>coinsurance</strong></td>
<td>None</td>
</tr>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>30% <strong>coinsurance</strong>, except routine physicals &amp; immunizations not covered</td>
<td>You may have to pay for services that aren't preventative. 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>10% <strong>coinsurance</strong></td>
<td>30% <strong>coinsurance</strong></td>
<td>None</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% <strong>coinsurance</strong></td>
<td>30% <strong>coinsurance</strong></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, deductible doesn't apply: $10 (retail), $20 (mail order)</td>
<td>30% <strong>coinsurance</strong>, deductible doesn't apply (retail)</td>
<td>Covers 30 day supply (retail), 31-90 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. Review your formulary for prescriptions requiring step therapy for coverage. Your cost will be higher for choosing Brand over Generics; cost difference penalty doesn't apply to out-of-pocket limit. Maintenance drugs- no refill restrictions or penalties apply. Members save with lower <strong>copays</strong> at CVS Caremark® Mail Service Pharmacy or CVS Pharmacy.</td>
</tr>
</tbody>
</table>

More information about **prescription drug coverage** is available at [www.aetnapharmacy.com/advancedcontrol](http://www.aetnapharmacy.com/advancedcontrol).
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Alternate drugs</td>
<td>In-Network Provider (You will pay the least)</td>
<td>Copay/prescription, deductible doesn't apply: $45 (retail), $90 (mail order)</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Non-preferred brand drugs</td>
<td>Out-of-Network Provider (You will pay the most)</td>
<td>30% coinsurance, deductible doesn't apply (retail)</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>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>------------------------------</td>
<td>----------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Specialty drugs</td>
<td>Copay/prescription, deductible doesn't apply: 40%, $120 maximum</td>
<td>In-Network Provider (You will pay the least) Out-of-Network Provider (You will pay the most) All prescriptions must be filled through the Aetna Specialty Performance Pharmacy Network. Precertification required for coverage. Maximum: 30 day supply.</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% coinsurance</td>
<td>30% coinsurance None</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>30% coinsurance None</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$150 copay/visit, deductible doesn't apply</td>
<td>Out-of-network emergency use paid the same as in-network. No coverage for non-emergency use.</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency medical transportation</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Urgent care</td>
<td>$50 copay/visit, deductible doesn't apply</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>10% coinsurance</td>
<td>30% coinsurance Penalty of $500 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>30% coinsurance 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>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------</td>
<td>--------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office &amp; other outpatient services: $25 copay/visit, deductible doesn't apply</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>10% coinsurance</td>
<td>Penalty of $500 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</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 $500 for failure to obtain pre-authorization for out-of-network care may apply.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Childbirth/delivery professional services</td>
<td>10% 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 $500 for failure to obtain pre-authorization for out-of-network care may apply.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Childbirth/delivery facility services</td>
<td>10% 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 $500 for failure to obtain pre-authorization for out-of-network care may apply.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>10% coinsurance</td>
<td>120 visits/calendar year. Penalty of $500 for failure to obtain pre-authorization for out-of-network care.</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>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>---------------------------</td>
<td>-------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Rehabilitation services</td>
<td>$40 copay/visit, deductible doesn't apply</td>
<td>90 visits/calendar year for Speech Therapy.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Habilitation services</td>
<td>$25 copay/visit, deductible doesn't apply</td>
<td>None</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Skilled nursing care</td>
<td>10% coinsurance</td>
<td>Penalty of $500 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Durable medical equipment</td>
<td>10% coinsurance</td>
<td>Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Hospice services</td>
<td>10% coinsurance</td>
<td>Penalty of $500 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>$40 copay/visit, deductible doesn't apply</td>
<td>1 routine eye exam/12 months.</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's glasses</td>
<td>Not covered</td>
<td>Not covered.</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's dental check-up</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.)
Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)

- Acupuncture - 10 visits/calendar year for disease, injury & chronic pain.
- Bariatric surgery
- Chiropractic care
- Infertility treatment - Fertility treatments are administered through Progyny. Please call (866) 881-4029 to activate benefit.
- Private-duty nursing
- Routine eye care (Adult) - 1 routine eye exam/12 months.

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
- 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 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:
- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-888-982-3862. 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: $900
- Specialist copayment: $40
- Hospital (facility) coinsurance: 10%
- Other coinsurance: 10%

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>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$900</td>
</tr>
<tr>
<td>Copayments</td>
<td>$10</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,100</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $60
- The total Peg would pay is: **$2,070**

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: $900
- Specialist copayment: $40
- Hospital (facility) coinsurance: 10%
- Other coinsurance: 10%

This EXAMPLE event includes services like:
- Primary care physician office visits (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs
- Diabetic supplies (glucose meter)

**Total Example Cost:** $5,600

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$100</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $20
- The total Joe would pay is: **$1,320**

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

- The plan’s overall deductible: $900
- Specialist copayment: $40
- Hospital (facility) coinsurance: 10%
- Other coinsurance: 10%

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>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$400</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: **$400**
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 unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, disability, gender identity or sexual orientation.

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 companies, including Aetna Life Insurance Company and its affiliates (Aetna).
TTY: 711

Language Assistance:

To access language services at no cost to you, call 1-888-982-3862.

Albanian - Për shërbime për kthimi falas për ju, telefononi 1-888-982-3862.

Amharic - የወንቀስ ከሚያስፋል ይልልም። ከẓለፋል ከኩለፋል 1-888-982-3862 ይፇፋል።

Arabic - للحصول على الخدمات اللغوية دون أي تكلفة، الاتصال على الرقم 1-888-982-3862.

Armenian - Մաքեսեր էջից կստանան ինչպես օգնեք, համար քաղաքականություն 1-888-982-3862 հեռախոսահամարով:

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

Bantu-Kirundi - Kugira uronke serivisi z’indimi atakiguzi, hamagara 1-888-982-3862.

Bengali-Bangala - আপনাকে বিনামূল্যে ভাষা পরিবর্তন করতে হবে এই মাধ্যম প্রয়োজন এনে নে, 1-888-982-386।

Bisayan-Visayan - Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-888-982-3862.

Burmese -သင်◌့ေအ�ျဖင္◌့အေခၾက္◌့မပးရပဲဘာသာစကား၀န္ေ◌ဆာင�ႈမ်ားရရွိႏ◌ု◌ိင�န္1-888-982-3862သို႕ဖုန္◌းေ◌ခၚဆု昶ပါ။

Catalan - Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-888-982-3862.

Chamorro - Para un hago' i setbision lengguáhi ni dibáte para hâgu, ágang 1-888-982-3862.

Cherokee - ᎨᏩᎨᏍᏗ ᎏᏚᏬᏂᎮᏗ ᎤᏳᏩᏗᏛᏗᏗᏣᏟᏗᏗᏛᏗ 1-888-982-3862.

Chinese - 如欲使用免費語言服務，請致電 1-888-982-3862.

Choctaw - Anumpa toshholi I toskvli ya peh pilla ho ish I paya hinla, I paya 1-888-982-3862.

Cushite - Tajaajiiloota afaanii garuu bilisaa ati argaachuuf, bilbili 1-888-982-3862.

Dutch - Voor gratis toegang tot taaldiensten, bell 1-888-982-3862.

French - Afin d'accéder aux services langagiers sans frais, composez le 1-888-982-3862.

French Creole - Pou jwenn sèvis lang gratis, rele 1-888-982-3862.

German - Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-888-982-3862 an.

Greek - Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-888-982-3862.

Gujarati - તમારેકોઇ ખચના ભાષાની સેટિફિસોની પ્રક્રિયા માટે, કોલ કરો 1-888-982-3862.
No ka walaʻau ʻana me ka lawelawe ʻölelo e kahea aku i kēia helu kelepona 1-888-982-3862. Kāki ʻole ʻia kēia kōkua nei.
Punjabi - 
ਤੁਹਾਡੇ ਲਈ ਇਬਨੀ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੀ ਲਿਖੀ, 1-888-982-3862 'ਤੇ ਫ਼ੋਨ ਕਰੋ।

Romanian - 
Pentru a accesa gratuit serviciile de limbă, apelați 1-888-982-3862.

Russian - 
Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-888-982-3862.

Samoan - 
Mo le mauina o auau naga tau gagana e aunoa ma se toto, vala’au le 1-888-982-3862.

Serbo-Croatian - 
Za besplatne prevodilačke usluge pozovite 1-888-982-3862.

Spanish - 
Para acceder a los servicios de idiomas sin costo, llame al 1-888-982-3862.

Sudanic-Fulfude - 
Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-888-982-3862.

Swahili - 
Kupata huduma za lugha bila malipo kwako, piga 1-888-982-3862.

Syriac - 
ܐܸܢ ܐܣܢܝܼܩܵܝܼܗܸܠܡܼܿܬܹܐ ܒܠܸܫܵܢܵܐ ܡܼܿܓܵܢܵܐܝܼܬ, ܘܿܢ ܝܼܡܩܪ 1-888-982-3862

Tagalog - 
Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-888-982-3862.

Telugu - 
ఇకె జాగ్రత్త వివిధ సేవలు అంతర్భూమిక ప్రత్యేకతలు, 1-888-982-3862 కొలువు కేస్టే.

Thai - 
หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-888-982-3862.

Tongan - 
Kapau ‘oku ke fiema’u ta’etööngi ‘a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-888-982-3862.

Trukese - 
Ren omw kopwe angei aninisin eman chon awewe (ese kamo), kopwe kori 1-888-982-3862.

Turkish - 
Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-888-982-3862 numarayi arayın.

Ukrainian - 
Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-888-982-3862.

Urdu - 
پر ﺑﺎت ﮐرﯾں۔ 1-888-982-3862 ﭘر ﻣﺗﻌﻠﻘہ ﺧدﻣﺎت ﺣﺎﺻل ﮐرﻧﮯ ﮐﮯ ﻟﯾﮯ،

Vietnamese - 
Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-888-982-3862.

Yiddish - 
1-888-982-3862 צו צוטריט שּפרַאך בַאדינונגען אין קייןּ פרייַז צו איר, רוף

Yoruba - 
Lati wọnú avon isẹ èdè l’ofe fun ọ, pe 1-888-982-3862.