### Important Questions | Answers | Why This Matters:

| What is the overall deductible? | In-Network: Individual $900 / Family $1,800. Out-of-Network: Individual $2,000 / Family $4,000. | 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. Emergency care & prescription drugs; plus in-network office visits & preventive care 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: Individual $4,000 / Family $6,850. Out-of-Network: Individual $6,000 / Family $12,000. | 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 limits until the overall family out–of–pocket limit has been met. |
| What is not included in the out-of-pocket limit? | Premiums, balance-billing charges, health care this plan doesn’t cover & penalties for failure to obtain pre-authorization for services. | 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. See www.aetna.com/docfind or call 1-888-982-3862 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.

<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, <strong>deductible</strong> doesn’t apply</td>
<td>30% <strong>coinsurance</strong></td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$40 <strong>copay</strong>/visit, <strong>deductible</strong> doesn’t apply</td>
<td>30% <strong>coinsurance</strong></td>
<td>None</td>
</tr>
<tr>
<td></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 preventive. Ask your <strong>provider</strong> if the services needed are preventive. Then check what your <strong>plan</strong> 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></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>Preferred drugs</td>
<td><strong>Copay</strong>/prescription, <strong>deductible</strong> doesn’t apply: $10 (retail), $20 (mail order)</td>
<td>30% <strong>coinsurance after copay</strong>/prescription, <strong>deductible</strong> doesn’t apply: $10 (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 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 Alternate drugs over Preferred drugs; cost difference penalty doesn’t apply to out-of-pocket limit.</td>
</tr>
<tr>
<td></td>
<td>Alternate drugs</td>
<td><strong>Copay</strong>/prescription, <strong>deductible</strong> doesn’t apply: $45 (retail), $90 (mail order)</td>
<td>30% <strong>coinsurance after copay</strong>/prescription, <strong>deductible</strong> doesn’t apply: $45 (retail)</td>
<td></td>
</tr>
</tbody>
</table>

More information about **prescription drug coverage** is available at [www.aetnapharmac](http://www.aetnapharmac).
<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>y.com/advancedcontrol</td>
<td>Non-preferred drugs</td>
<td>In-Network Provider (You will pay the least): 40% copay with minimum &amp; maximum/prescription, deductible doesn't apply: $60 minimum &amp; $120 maximum (retail), $120 minimum &amp; $240 maximum (mail order)</td>
<td>Out-of-Network Provider (You will pay the most): 30% coinsurance after copay/prescription, deductible doesn't apply: 40% copay with minimum &amp; maximum/prescription, $60 minimum &amp; $120 maximum (retail)</td>
</tr>
<tr>
<td>Specialty drugs</td>
<td></td>
<td>Applicable cost as noted above for generic or brand drugs</td>
<td>Applicable cost as noted above for generic or brand drugs</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</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>30% coinsurance</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>$150 copay/visit, deductible doesn't apply</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$50 copay/visit, deductible doesn't apply</td>
<td>30% coinsurance</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</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>30% coinsurance</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>Office &amp; other outpatient services: 30% coinsurance</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></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>Inpatient services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>Penalty of $500 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td>Office visits</td>
<td>No charge</td>
<td>30% 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>Childbirth/delivery professional services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Childbirth/delivery facility services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Home health care</td>
<td>10% coinsurance</td>
<td>30% 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>Rehabilitation services</td>
<td>$40 copay/visit, deductible doesn't apply</td>
<td>30% coinsurance</td>
<td>90 visits/calendar year for Speech Therapy.</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>$40 copay/visit, deductible doesn't apply</td>
<td>30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>Penalty of $500 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.</td>
</tr>
<tr>
<td>Hospice services</td>
<td>10% coinsurance</td>
<td>30% 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></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children's eye exam</td>
<td>$40 copay/visit, deductible doesn't apply</td>
<td>30% coinsurance</td>
<td>1 routine eye exam/12 months.</td>
</tr>
<tr>
<td>Children's glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Children's dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered.</td>
</tr>
</tbody>
</table>
### Excluded Services & Other Covered Services:

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

- 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.

### 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
- Hearing aids - $3,000 maximum/3 years.
- Infertility treatment - For more information & exceptions, see policy document provided by your employer or call the number on your ID card.
- 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](http://www.dol.gov/ebsa/healthreform).
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

### Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-888-982-3862.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [http://www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).
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:

**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**: $60

**The total Peg would pay is**: $2,070

### 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
- Durable medical equipment (*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**: $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>$900</td>
</tr>
<tr>
<td>Copayments</td>
<td>$400</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**: $0

**The total Mia would pay is**: $1,300

---

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 866-393-0002.

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

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

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

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

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

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

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

Language Assistance:

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

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-888-982-3862.
Amharic - እርግ Fighters ከ ከвшейን ከ 1-888-982-3862 ያስ ያርሱን.
Arabic - للمساعدة في (اللغة العربية)، الراجع الاتصال على الرقم المجاني 1-888-982-3862.
Armenian - Բերձիչ գործարքում արձագանթույք (հայերեն) գրանցի 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 - မြန်မာစိုး အမှတ် 1-888-982-3862 လေ့လာသောက်သည်။
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 gástu.
Cherokee - ᎠᏜᏣᏛᏤ ᎠᏔᏳᏩ ᎠᏕᏛᏣ ᎠᏔᏳᏤ ጯ Ꮳ T (GWY) ᎠᏔᎹᏨ'IS 1-888-982-3862 ᎤᏣ ᎣᏧᏨ ᎨᏣᏢ.Ꮺ.Ꮳ ᏭᏩᏌ.
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 argachuuuf lakkokkofsa bilbilaa 1-888-982-3862 irratti bilisaan bilbilaa.
Dutch - Bel voor tolk- en vertaal- diensten 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 લાભાય માટે કોઈ પણ અર્થ વચ્ચે 1-888-982-3862 પર કોલ કરો.
Hindi - हिन्दी में भाषा सहायता के लिए, 1-888-982-3862 पर मुफ्त कॉल करें।

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

Ibo - Maka enyemaka asụṣụ na Igbo kpọọ 1-888-982-3862 na akwughị ọgwo ọ bula

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 - 1-888-982-3862

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

Kru-Bassa - Be’m ké gbo-kpá-kpá dyé pidýi ñe Bассу-wuquùn we, ɗá 1-888-982-3862

Kurdish - 1-888-982-3862

Laotian - 1-888-982-3862

Marathi - कोणत्याही भाषा सेवा प्राप्त करण्यासाठी, 1-888-982-3862 वर फोन करा.

Marshallese - Ñan bôk jipaŋ ilo Kajin Majol, kallok 1-888-982-3862 ilo ejjelok wônân.

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

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

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