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: EE Only $1,500; EE+ Family $3,000. Out-of-Network: EE Only $1,500; EE+ Family $3,000.</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 policy, the overall family deductible must be met before the plan begins to pay.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. In-network preventive care is 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: EE Only $2,500; EE+ Family $3,850. Out-of-Network: EE Only $5,000; EE+ Family $10,000.</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, the overall family out–of–pocket limit must be 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>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<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><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% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No charge</td>
<td>30% coinsurance, deductible doesn't apply; 30% coinsurance for mammograms; routine physicals &amp; immunizations not covered</td>
</tr>
<tr>
<td></td>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Preferred drugs</td>
<td>Copay/prescription: $10 (retail), $20 (mail order)</td>
<td>30% coinsurance after copay/prescription: $10 (retail)</td>
</tr>
<tr>
<td></td>
<td>Alternate drugs</td>
<td>Copay/prescription: $45 (retail), $90 (mail order)</td>
<td>30% coinsurance after copay/prescription: $45 (retail)</td>
</tr>
<tr>
<td></td>
<td>Non-preferred drugs</td>
<td>40% copay with minimum &amp; maximum/prescription: $60 minimum &amp; $120 maximum (retail), $120 minimum &amp; $240 maximum (mail order)</td>
<td>30% coinsurance after copay/prescription: 40% copay with minimum &amp; maximum/prescription, $60 minimum &amp; $120 maximum (retail)</td>
</tr>
</tbody>
</table>

Covers 31 day supply (retail), 32-100 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & 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 deductible or out-of-pocket limit. Maintenance drugs- no refill restrictions or penalties apply. Members save with lower copays at CVS Caremark® Mail Service Pharmacy or CVS Pharmacy. Deductible doesn't apply to certain preventive medications.

More information about **prescription drug coverage** is available at www.aetnapharmacy.com/advancedcontrol.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
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<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have outpatient surgery</td>
<td>Specialty drugs</td>
<td>Applyable cost as noted above for generic or brand drugs</td>
<td>All prescriptions must be filled through the Aetna Specialty Pharmacy Network. Precertification required for coverage.</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% coinsurance / 30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance / 30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Emergency room care</td>
<td>10% coinsurance</td>
<td>No coverage for non-emergency use. 30% coinsurance for non-emergency transport out-of-network.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>10% coinsurance</td>
<td>No coverage for non-urgent use.</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: 10% coinsurance / 30% coinsurance</td>
<td>Penalty of $500 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>10% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>Penalty of $500 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td></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></td>
<td>Childbirth/delivery facility services</td>
<td>10% coinsurance</td>
<td>None</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></td>
<td>Rehabilitation services</td>
<td>10% coinsurance</td>
<td>90 visits/calendar year for Speech Therapy.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>10% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></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>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>
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<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><strong>If your child needs dental or eye care</strong></td>
<td><strong>Durable medical equipment</strong></td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td><strong>Hospice services</strong></td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td><strong>Children's eye exam</strong></td>
<td>10% coinsurance, deductible doesn't apply</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td><strong>Children's glasses</strong></td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Children's dental check-up</strong></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.

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:

- 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.
- 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: $1,500
- Specialist coinsurance: 10%
- 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></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,000</td>
</tr>
<tr>
<td><strong>What isn't covered</strong></td>
<td>$60</td>
</tr>
</tbody>
</table>

The total Peg would pay is **$2,560**

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: $1,500
- Specialist coinsurance: 10%
- 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></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$800</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$50</td>
</tr>
<tr>
<td><strong>What isn't covered</strong></td>
<td>$20</td>
</tr>
</tbody>
</table>

The total Joe would pay is **$2,370**

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

- The plan's overall deductible: $1,500
- Specialist coinsurance: 10%
- 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></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$10</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$100</td>
</tr>
<tr>
<td><strong>What isn't covered</strong></td>
<td>$0</td>
</tr>
</tbody>
</table>

The total Mia would pay is **$1,610**

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), CRCoordinator@aetna.com.

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

**Aetna** is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates.
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 - እንግሉት ከበን ዓለምኝ እና 1-888-982-3862 ያለቀ ያሆን
Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-888-982-3862
Armenian - կարող զանգի գնալու համար զանգի 1-888-982-3862 ստորագրեք զանգի;
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 - Kyaing paa og piine 1-888-982-3862 yi ni ****************************************************************************
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 - ᎠᏛᎨᏯ ᎨᏬᏂᎨᏳ ᎤᏨᏯᏣᏲᏩᏪᏪ ᎪᏩ T (GWY) 珩위원회 1-888-982-3862 Ọ’Ò T L AGGDI JEGR I HRRY.
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 1-888-982-3862
Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-888-982-3862.
French - Pour une assistance linguistique en français appeler le 1-888-982-3862 sans frais.
French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-982-3862 gratis.
German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-982-3862 an.
Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-982-3862 χωρίς χρέωση.
Gujarati - ગુજરાતીમાં ભાષાના સહાય માટે કોઈ પણ અર્થ નગર 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 asuşụ na Igbo kpọọ 1-888-982-3862 na akwughị ụgwọ ọ bụla
Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-982-3862 nga awan ti bayadanyo.
Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-982-3862.
Japanese - 日本語で援助をご希望の方は、1-888-982-3862まで無料でお電話ください。
Karen - ကြိုးစားသူတို့အတွက် 1-888-982-3862 အကြံပြုပါသည်။
Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862 번으로 전화해 주십시오.
Kru-Bassa - Be’m ké gbo-kpá-kpá dyé pidyi dë Bäsôo-wuquün wëc, qá 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 - कोणत्याही शुल्काशी भाषा सेवा प्राप्त करण्यासाठी, 1-888-982-3862 वर फोन करा.
Marshallese - Ŋan bok jipaŋ ilo Kajin Majol, kallok 1-888-982-3862 ilo ejjelok wōnān.
Mon-Khmer, Cambodian - មាស៊ីនខ្មែរ យើងអាចទទួលបានសេវារបស់ប្រទេសរបស់យើងបាន 1-888-982-3862 ការទទួលសេវាដែលប្រសើរ
Navajo - T'áá shi shizaad k'eňji bee shiká a'doowol niñizingo Diné k'eňji koji' t'áá jíík'e hólne' 1-888-982-3862
Nepali - (नेपाली) मा नि:ःशुल्क भाषा सहायता पाउनका लागि 1-888-982-3862 मा फोन गर्नुहोस्।
Nilotic-Dinka - Tén kuɔɔny é thok é Thuonjään col 1-888-982-3862 kecín ayóc.
Norwegian - For språkassistanse på norsk, ring 1-888-982-3862 kostnadsfritt.
Panjabi - ਪੰਜਾਬੀ ਦੀ ਵिभਾਗੀ ਸੰਸਦੀ ਮਾਰਕੇਟ੍ ਲਾਗੀ, 1-888-982-3862 ਤੇ ਮੁੱਢਾ ਵਰਤਾਤ।
Persian - برای اهتمام به زبان فارسی با شماره 1-888-982-3862 بحث نشان دهید. انگلیسی
Polish - Aby uzyskać pomoc w języku polskim, zadzwonić bezpłatnie pod numer 1-888-982-3862.
Portuguese - Para obter assistência linguística em português ligue para o 1-888-982-3862 gratuitamente.
Romanian - Pentru asistență lingvistică în româneste telefonați la numărul gratuit 1-888-982-3862
To get help from a Russian-speaking translator, call the free number 1-888-982-3862.

To get help from a Samoan-speaking translator, call 1-888-982-3862 and follow the instructions.

For Serbo-Croatian, call 1-888-982-3862 for free assistance.

For Spanish, call 1-888-982-3862 for free assistance.

For Sudanic-Fulfude, call 1-888-982-3862 for free assistance.

For Swahili, call 1-888-982-3862 for free assistance.

For Syriac, call 1-888-982-3862.

For Tagalog, call 1-888-982-3862 for free assistance.

For Telugu, call 1-888-982-3862 for free assistance.

For Thai, call 1-888-982-3862 for free assistance.

For Tongan, call 1-888-982-3862 for free assistance.

For Trukese, call 1-888-982-3862 for free assistance.

For Turkish, call 1-888-982-3862 for free assistance.

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For Urdu, call 1-888-982-3862 for free assistance.

For Vietnamese, call 1-888-982-3862 for free assistance.

For Yiddish, call 1-888-982-3862 for free assistance.

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