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 1-800-370-4526. 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 1-800-370-4526 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 $0 / Family $0 Out-of-Network: Individual $750 / Family $2,000.</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, preventive care, inpatient hospital services, outpatient hospital services &amp; prescription drugs; plus in-network office visits 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 $3,000 / Family $5,000. Out-of-Network: Individual $4,000 / Family $6,000. Prescription drugs: Individual $800 / Family $1,600.</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. Even though you pay these expenses, they don’t count toward the out–of–pocket limit.</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></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 1-800-370-4526 for a list of 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>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$20 <strong>copay</strong>/visit</td>
<td>Includes Internist, General Physician, Family Practitioner or Pediatrician.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$35 <strong>copay</strong>/visit</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care/ screening / immunization</td>
<td>No charge</td>
<td>You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. 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>$35 <strong>copay</strong>/visit for hospital; $25 <strong>copay</strong>/visit for free standing facility</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$50 <strong>copay</strong>/visit for hospital; $25 <strong>copay</strong>/visit for free standing facility</td>
<td>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>
</tbody>
</table>
| If you need drugs to treat your illness or condition | Drug Tier 1 – includes preferred generics and some lower-cost brand products | 31 Day Retail: $5 90 Day Mail Order $5 | Not Covered | Covers 31 day supply (retail), 90 day supply (mail order – NoviXus.com, 888-240-211 www.NoviXus.com  
• Includes contraceptive drugs & devices obtainable from a pharmacy, oral fertility drugs.  
• Review formulary for $0 co-pay covered products.  
• Prior Authorization may be required. Step therapy may be required  
• Mandatory generic when available. |
| Prescription drug coverage is administered by Navitus 1-866-333-2757 | Drug Tier 2 – includes preferred brand products and some higher-cost non-preferred generics | 31 Day Retail: $35 90 Day Mail Order: $70  
31 Day Retail: $50 90 Day Mail Order: $100 | Not Covered | |
<p>| More information about prescription drug coverage is available at <a href="http://www.Navitus.com">www.Navitus.com</a> | Drug Tier 3 - includes non-preferred products; may include some high-cost, non-preferred generics | 31 Day Retail: $100 90 Day Mail Order: $200 | Not covered | |
| | Drug Tier 4 – includes specialty products available at specialty pharmacies | 31 Day Retail: $100 90 Day Mail Order: $200 | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | $100 copay/visit | None | |
| | Physician/surgeon fees | $35 copay/visit | 20% coinsurance | None |
| If you need immediate medical attention | Emergency room care | $150 copay/visit | 10% coinsurance after $100 copay/visit, deductible doesn't apply | 20% coinsurance for non-emergency use. |
| | Emergency medical transportation | No charge | No charge | 20% coinsurance for non-emergency transport. |
| | Urgent care | $35 copay/visit | $35 copay/visit, after deductible | No coverage for non-urgent use. |</p>
<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><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>$250 copay/stay</td>
<td>10% coinsurance after $250 copay/stay, deductible doesn't apply</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>$35 copay/visit</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>Office $35 copay/visit Other outpatient services: $25 copay/visit</td>
<td>Office: 20% coinsurance;</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>$250 copay/stay</td>
<td>10% coinsurance after $250 copay/stay, deductible doesn't apply</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>$35 copay/pregnancy</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$250 copay/stay</td>
<td>10% coinsurance after $250 copay/stay, deductible doesn't apply</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Home health care</td>
<td>No charge</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$35 copay/visit,</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$35 copay/visit,</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</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>----------------------</td>
<td>-----------------------</td>
<td>---------------------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>$250 copay/stay</td>
<td>10% coinsurance after $250 copay/stay, deductible doesn't apply</td>
<td>100 days/calendar year. Penalty of 50%, not to exceed $250, of allowed amount for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>No charge</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Hospice services</td>
<td>$250 copay/stay, for inpatient; no charge for outpatient</td>
<td>$250 copay/stay, deductible doesn't apply for inpatient; no charge for outpatient</td>
<td>Penalty of 50%, not to exceed $250, of allowed amount for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
</tbody>
</table>

### If your child needs dental or eye care
- Children's eye exam: Not covered
- Children's glasses: Not covered
- Children's dental check-up: Not covered

### 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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Adult & Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult & Child)
- 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.)

- Bariatric surgery
- Chiropractic care.
- Hearing aids – Limited to $4,000 maximum every 3 years
- Infertility Treatment - Cover 3 cycles of IVF/ART treatments; covers cryopreservation of eggs, embryos and sperm for members undergoing treatment that may impact fertility.
- Private-duty nursing – Limited to $400/day.
- Mental Health – Maternal Depression coverage under infant’s plan.
- Teladoc – Telemedicine service made available through Aetna for 24 hour, on-demand general medical, dermatology, and behavioral health. Standard $10 co-pay.

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 1-800-370-4526.
- 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: www.dol.gov/agencies/ebsa
- 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.ccio.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 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 1-800-370-4526.
- 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.
- Navitus directly by calling the toll free number on your Prescription ID card, or by calling the general toll free number at 1-866-333-2757.
- 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 www.dol.gov/agencies/ebsa.
- 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.ccio.cms.gov.
Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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: $0
- Specialist copayment: $35
- Hospital (facility) copayment: $250
- Other copayment: $0

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: $12,800

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$555</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

What isn't covered:
Limits or exclusions: $0

The total Peg would pay is: $555.

Managing Joe’s type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan’s overall deductible: $0
- Specialist copayment: $35
- Hospital (facility) copayment: $250
- Other copayment: $0

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: $7,400

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,150</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

What isn’t covered:
Limits or exclusions: $0

The total Joe would pay is: $1,150.

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

- The plan’s overall deductible: $0
- Specialist copayment: $35
- Hospital (facility) copayment: $250
- Other copayment: $0

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: $1,900

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$570</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: $570.

Note: These numbers assume the patient does not participate in the plan’s wellness program. If you participate in the plan’s wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-370-4526.

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 1-800-370-4526.

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, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides 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: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705),

Email: 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 (Aetna).
TTY: 711

Language Assistance:

For language assistance in your language call 1-800-370-4526 at no cost.

Albanian - Për asistencë në gjihën shqipe telefononi falas në 1-800-370-4526.
Amharic - እስቀመASF እንዘኝ ያለው እስቀመASF 1-800-370-4526 እና ያለው ያለውASF እስቀመASF እስቀመASF
Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-370-4526
Armenian - Բնօրինք գնդակում պատգամները (հայերեն) զանգի 1-800-370-4526 առանց գնով:
Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.
Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-800-370-4526 ku busa
Bengali-Bangla - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-800-370-4526-এ কল করন।
Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-370-4526 nga walay bayad.
Burmese - အာလျင်မူသားအာလျင်မူသား အာလျင်မူသား အာလျင်မူသား အာလျင်မူသား 1-800-370-4526 တွင် အာလျင်မူသား
Catalan - Per rebre assistència en (català), truqui al número gratuït 1-800-370-4526.
Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-800-370-4526 sin gåstu.
Chinese - 欲取得繁體中文語言協助，請撥打 1-800-370-4526，無需付費。
Choctaw - (Chahta) anumpa ya apela a chi l paya hinla 1-800-370-4526.
Cushite - Gargaarsa afana Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-800-370-4526 irratti bilisaan bilbilaa.
Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-370-4526.
French - Pour une assistance linguistique en français appeler le 1-800-370-4526 sans frais.
French Creole - Pou jwenn asistan nan lang Kreyòl Ayisyen, rele nime wo 1-800-370-4526 gratis.
German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-370-4526 an.
Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-370-4526 χωρίς χρέωση.
Gujarati - જરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ભાષામાં 1-800-370-4526 પર કોલ કરો.
Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-800-370-4526. Kāki ‘ole ‘ia kēia kōkua nei.
Hindi - हिन्दी में भाषा सहायता के लिए, 1-800-370-4526 पर मुक्त कॉल करें।
Hmong - Yog xav tau kev pab txhaib u s Hmoob hu dawb tau rau 1-800-370-4526.
Ibo - Maka enyemaka asụṣu na Igbo kpọọ 1-800-370-4526 na akwụgwị ụgbọ bụla
Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-370-4526 nga awan ti bayadanyo.
Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-370-4526.
Japanese - 日本語で援助をご希望の方は、1-800-370-4526 まで無料でお電話ください。
Karen - ლაო კირ ახალგაზრიდელ პირებს დასაშვებელ უფლება ჰაესთა 1-800-370-4526 იპოსტოში ყალიბური საშიშეფო.
Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862번으로 전화해 주십시오.
Kru-Bassa - Be'm ké gbo-kgá-kpá dyé pidiq ké Baso wuđi we, qa 1-800-370-4526
Kurdish - برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 یه خورايی یهیوندی بکین.
Laotian - ພາສາລາວ ເພີ່ມຂຶ້ນ na Igbo kpọọ 1-800-370-4526 ໄດ້ເຮັດດ້ວຍເພີ່ມຂຶ້ນ.
Marathi - तीलभाषा (मराठी) सहायता 1-800-370-4526 राजस्थान के विभाग में.
Marshallese - Ñan bök jipañ ilo Kajin Majol, kallok 1-800-370-4526 ilo eijelok wōnān.
Micronesian - Ohng palien sawas en souen kawewe ni omm lokaia Ponape koahl 1-800-370-4526 ni sohte isais.
Pohnpeian - Pohnpei sawas ni omm lokaia Ponape koahl 1-800-370-4526 ni sohte isais.
Mon-Khmer, Cambodian - Khmer, lao, Laos and Cambodian speakers please call 1-800-370-4526.
Navajo - T‘áá shí shíí awww shíí awwó wíí Díné k'éjí kóójí' t‘áá jííke hólne' 1-800-370-4526
Nepali - नेपाली भाषा सहायता 1-800-370-4526 मा फोन गर्नुहोस्
370-4526 मा फोन गर्नुहोस्
Nilotic-Dinka - Tên kuony è thok è Thoorján col 1-800-370-4526 kecín ayóc.
Norwegian - For språkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt.
Panjabi - ਪੰਜਾਬੀ ਸ਼ਾਂਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਦੀ ਲਾਇਨ 1-800-370-4526 ਨੇ ਭਾਸ਼ਾ ਵਾਲਾ ਬਾਜ਼ਾਰ।
Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-800-370-4526 aa. Es Aaruf koschtet nix.
Persian - برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 بروند هیچ‌هی زنیه ای تماس بگیرید. انگلیسی
Polish - Aby uzyskať pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-370-4526.
Para obter assistência linguística em português ligue para o 1-800-370-4526 gratuitamente.

Pentru asistență lingvistică în română, telefonați la numărul gratuit 1-800-370-4526.

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-370-4526.

Mo fesoasoani tau gagana I le Gagana Samoa vala’au le 1-800-370-4526 e aunoa ma se toto.

Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-370-4526.

Para obtener asistencia lingüística en español, llame sin cargo al 1-800-370-4526.

Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-800-370-4526. Njodi woo fawaaki on.

Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-370-4526 bila malipo.

Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-370-4526 nang walang bayad.

ทางทางภาษาเป็นภาษาไทย โทร 1-800-370-4526 ชำระเงินราย สำหรับความช่วยเหลือ ฟรี ไม่มีค่า
<table>
<thead>
<tr>
<th>Language</th>
<th>Translation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tongan</td>
<td>Kapau ʻoku fiemaʻu hā tokoni ʻi he lea faka-Tonga telefoni 1-800-370-4526 ʻo ʻikai hā ʻotōngi.</td>
</tr>
<tr>
<td>Trukese</td>
<td>Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-800-370-4526 nge esapw kamé ngonuk.</td>
</tr>
<tr>
<td>Turkish</td>
<td>(Dil) çağırsı dil yardım için. Hiçbir ücret ödemeden 1-800-370-4526.</td>
</tr>
<tr>
<td>Ukrainian</td>
<td>Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-370-4526.</td>
</tr>
<tr>
<td>Urdu</td>
<td>ارکائی کہتی ہے (کپسن چوک) کوپے کےکےری 1-800-370-4526 نگے اسپو کمے نگونک.</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>Để được hỗ trợ người nói (ngôn ngữ), hãy gọi miễn phí đến số 1-800-370-4526.</td>
</tr>
<tr>
<td>Yiddish</td>
<td>פאר stret גירל און אייזיש רופטן פאר, פאר גירל אפפצל.</td>
</tr>
<tr>
<td>Yoruba</td>
<td>Fún ǹranlọwọ nìpa èdè (Yorùbá) pe 1-800-370-4526 lái san owó kankan r</td>
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