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, https://www.aetna.com/sbcsearch/getpolicydocs?u=080700-110020-012242 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 $500 / Family $1,000. Out-of-Network: Individual $1,000 / 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>
</tbody>
</table>
| 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? | Yes. For prescription drugs- Individual $50 / Family $100. There are no other specific deductibles. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.

| What is the out-of-pocket limit for this plan? | In-Network: Individual $2,700 / Family $5,400. Out-of-Network: Individual $4,800 / Family $9,600. | 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 http://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>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<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><strong>In-Network Provider (You will pay the least)</strong></td>
<td><strong>Out-of-Network Provider (You will pay the most)</strong></td>
</tr>
<tr>
<td></td>
<td>$45 copay/visit, deductible doesn't apply</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$60 copay/visit, deductible doesn't apply</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>30% coinsurance, except no charge for well child &amp; child immunizations</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 generic drugs</td>
<td>Copay/prescription, after specific deductible: $10 (retail), $25 (mail order)</td>
<td>20% coinsurance after copay/prescription, after specific deductible: $10 (retail)</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>Copay/prescription, after specific deductible: $25 (retail), $62.50 (mail order)</td>
<td>20% coinsurance after copay/prescription, after specific deductible: $25 (retail)</td>
</tr>
<tr>
<td></td>
<td>Non-preferred generic/brand drugs</td>
<td>Copay/prescription, after specific deductible: $50 (retail), $125 (mail order)</td>
<td>20% coinsurance after copay/prescription, after specific deductible: $50 (retail)</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Applicable cost as noted above for generic or brand drugs</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$75 copay/visit, deductible doesn't apply</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>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><strong>If you need immediate medical attention</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency room care</td>
<td>$250 copay/visit, deductible doesn't apply</td>
<td>$250 copay/visit, deductible doesn't apply</td>
<td>No coverage for non-emergency use. Out-of-network emergency use paid the same as in-network.</td>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td>0% coinsurance</td>
<td>0% coinsurance</td>
<td>Non-emergency transport: not covered, except if pre-authorized. Out-of-network emergency use paid the same as in-network.</td>
</tr>
<tr>
<td>Urgent care</td>
<td>$50 copay/visit, deductible doesn't apply</td>
<td>30% coinsurance</td>
<td>No coverage for non-urgent use.</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility fee (e.g., hospital room)</td>
<td>$500 copay/stay</td>
<td>30% coinsurance</td>
<td>Max copay/calendar year: $1,500 in-network. Penalty of $400 (or 50% of allowed amount if less) for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>0% coinsurance</td>
<td>30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient services</td>
<td>Office: $45 copay/visit, deductible doesn't apply; other outpatient services: no charge</td>
<td>Office &amp; other outpatient services: 30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Inpatient services</td>
<td>$500 copay/stay</td>
<td>30% coinsurance</td>
<td>Max copay/calendar year: $1,500 in-network. Penalty of $400 (or 50% of allowed amount if less) for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td></td>
<td></td>
<td></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.) Max copay/calendar year: $1,500 in-network. Penalty of $400 (or 50% of allowed amount if less) for failure to obtain pre-authorization for out-of-network care may apply.</td>
</tr>
<tr>
<td>Childbirth/delivery professional services</td>
<td>0% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Childbirth/delivery facility services</td>
<td>$500 copay/stay</td>
<td>30% coinsurance</td>
<td></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></td>
<td></td>
<td>10% coinsurance, deductible doesn't apply</td>
<td>25% coinsurance, deductible doesn't apply</td>
</tr>
<tr>
<td></td>
<td>Home health care</td>
<td>$60 copay/visit, deductible doesn't apply</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>No charge</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>No charge</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>$500 copay/stay</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>$500 copay/stay for inpatient; except 0% coinsurance for outpatient</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Children's eye exam</td>
<td>No charge</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Cosmetic surgery                                                                                                         • Non-emergency care when traveling outside the U.S.                                                                                     • Weight loss programs - Except for required preventive services.</td>
</tr>
<tr>
<td>• Dental care (Adult &amp; Child)                                                                                                   • Private-duty nursing</td>
</tr>
<tr>
<td>• Glasses (Child)                                                                                                               • Routine foot care</td>
</tr>
<tr>
<td>• Long-term care</td>
</tr>
</tbody>
</table>
Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)

<table>
<thead>
<tr>
<th>Service</th>
<th>Limitations/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td>- 10 visits/calendar year for disease, injury &amp; chronic pain.</td>
</tr>
<tr>
<td>Bariatric surgery</td>
<td></td>
</tr>
<tr>
<td>Chiropractic care</td>
<td></td>
</tr>
<tr>
<td>Hearing aids</td>
<td>- 1 hearing aid per ear/3 years.</td>
</tr>
<tr>
<td>Infertility treatment</td>
<td>- For more information &amp; exceptions, see policy document using summary box link on page 1 or call the number on your ID card.</td>
</tr>
<tr>
<td>Routine eye care (Adult)</td>
<td>- 1 routine eye exam/24 months.</td>
</tr>
</tbody>
</table>

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:

- 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/ebsa/healthreform.
- For more information on your rights to continue coverage, contact the plan at 1-888-982-3862.
- 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 toll free 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 www.dol.gov/ebsa/healthreform.
- Department of Financial Services, Consumer Assistance Unit, 800-342-3736, https://www.dfs.ny.gov/consumers/health_insurance/home.
- 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 Community Health Advocates, Community Service Society of New York, 633 Third Avenue 10th Floor, New York, NY 10017, 1-888-614-5400, http://www.communityhealthadvocates.org/

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.
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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan’s overall deductible</td>
</tr>
<tr>
<td>Specialist copayment</td>
</tr>
<tr>
<td>Hospital (facility) copayment</td>
</tr>
<tr>
<td>Other coinsurance</td>
</tr>
<tr>
<td>This EXAMPLE event includes services like:</td>
</tr>
<tr>
<td>Specialist office visits (prenatal care)</td>
</tr>
<tr>
<td>Childbirth/Delivery Professional Services</td>
</tr>
<tr>
<td>Childbirth/Delivery Facility Services</td>
</tr>
<tr>
<td>Diagnostic tests (ultrasounds and blood work)</td>
</tr>
<tr>
<td>Specialist visit (anesthesia)</td>
</tr>
<tr>
<td>Total Example Cost</td>
</tr>
</tbody>
</table>

In this example, Peg would pay:

- Deductibles* | $500 |
- Copayments | $500 |
- Coinsurance | $100 |
- What isn’t covered |
- Limits or exclusions | $60 |
- The total Peg would pay is | $1,160 |

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

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan’s overall deductible</td>
<td>$500</td>
</tr>
<tr>
<td>Specialist copayment</td>
<td>$60</td>
</tr>
<tr>
<td>Hospital (facility) copayment</td>
<td>$500</td>
</tr>
<tr>
<td>Other coinsurance</td>
<td>0%</td>
</tr>
<tr>
<td>This EXAMPLE event includes services like:</td>
<td></td>
</tr>
<tr>
<td>Primary care physician office visits (including disease education)</td>
<td></td>
</tr>
<tr>
<td>Diagnostic tests (blood work)</td>
<td></td>
</tr>
<tr>
<td>Prescription drugs</td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment (glucose meter)</td>
<td></td>
</tr>
<tr>
<td>Total Example Cost</td>
<td>$5,600</td>
</tr>
</tbody>
</table>

In this example, Joe would pay:

- Deductibles* | $200 |
- Copayments | $1,100 |
- Coinsurance | $0 |
- 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)

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan’s overall deductible</td>
<td>$500</td>
</tr>
<tr>
<td>Specialist copayment</td>
<td>$60</td>
</tr>
<tr>
<td>Hospital (facility) copayment</td>
<td>$500</td>
</tr>
<tr>
<td>Other coinsurance</td>
<td>0%</td>
</tr>
<tr>
<td>This EXAMPLE event includes services like:</td>
<td></td>
</tr>
<tr>
<td>Emergency room care (including medical supplies)</td>
<td></td>
</tr>
<tr>
<td>Diagnostic test (x-ray)</td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment (crutches)</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation services (physical therapy)</td>
<td></td>
</tr>
<tr>
<td>Total Example Cost</td>
<td>$2,800</td>
</tr>
</tbody>
</table>

In this example, Mia would pay:

- Deductibles* | $500 |
- Copayments | $600 |
- Coinsurance | $0 |
- What isn’t covered |
- Limits or exclusions | $0 |
- The total Mia would pay is | $1,100 |

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: 1-888-982-3862.

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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 1-888-982-3862.

**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:

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 - እስከሆ እስከ ከ 1-888-982-3862 ይስ ያደጋል ከ襄_argachuf
Arabic - للمساعدة في (اللغة العربية)، الوجهاء الاتصال على الرقم المجاني 1-888-982-3862.
Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-888-982-3862 առանց գնով:
Bahasa-Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya.
Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-888-982-3862 ku busa
Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-888-982-3862-এ কল করুন।
Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-982-3862 nga walay bayad.
Burmese - 1-888-982-3862
Catalan - Per rebre assistència en (català), truqui al número gratuït 1-888-982-3862.
Chamorro - Para ayuda gi fino’ (Chamoru), âgang 1-888-982-3862 sin gástu.
Cherokee - (Chahta) anumpa ya apela a chi l paya hinla 1-888-982-3862.
Chew - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-888-982-3862 irratti bilisaan bilbilaa.
Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-888-982-3862.
French - Pour une assistance linguistique en français appeler le 1-888-982-3862 sans frais.
French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-982-3862 gratis.
German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-982-3862 an.
Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-982-3862 χωρίς χρέωση.
Gujarati - ગુજરાતીમાં ભાષા માટે કોઈ પણ પરસ્પર વચ્ચે 1-888-982-3862 પર કલ કરો.

Hindi - हिन्दी में भाषा सहायता के लिए, 1-888-982-3862 पर मुफ्त कॉल करें।

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

Ibo - Maka enyemaka asusu na Igbo kpoọ 1-888-982-3862 na akwụghị ụgwọ 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, puo 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 - ვთან და საუკეთესო ღირებულებით თანხმობა გამოყენებით 1-888-982-3862 უფრო მეტი იაპონურად.

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

Kru-Bassa - Êmèké gbo-kpá-kpá dyi piyi de Basósó-wuóóun weh, dà 1-888-982-3862

Kurdish - برای راهنمایی به زبان فارسی با شماره 982-982-888-888-870-01 په خویای پیام مندی بکن.

Laotian - ຄາຊາຍເກາະປາາກາຍເມືອງຫຼວງພູມແພກຊາວດາ, ອະບູດເຫຼືອ 1-888-982-3862 ສົດທ້າຍເພັດໃສ່.

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

Marshallese - Ñan bok jipañ ilo Kajin Majol, kallok 1-888-982-3862 ilo ejjelok wönän.

Micronesian-Pohnpeyan - Ohng palien sawas en soung kawewe ni omw lokaia Ponape koahl 1-888-982-3862 ni sohte isais.

Mon-Khmer, Cambodian - ភ្នំពេញប្រការណ៍ ភាសាខ្មែរ ភ្លាក់ប្រការណ៍ 1-888-982-3862 ភ្លាក់ប្រការណ៍ប្រការណ៍។

Navajo - Táá shi shizaad kéhjí bee shiká a'doowol ninízingo Diné kéhjí kójí t'áá jíílí k'hóní 1-888-982-3862

Nepali - (नेपाली) मा निश्चित भाषा सहायता पाउनका लागि 1-888-982-3862 मा फोन गर्नुहोस्।

Nilotic-Dinka - Tèn kuòonè thok è Thuñjìng col 1-888-982-3862 këcín ayôc.

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

Punjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-982-3862 ਦੇ ਮੁਫ਼ਤ ਕਾਲ ਬਾਣੀ।

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-982-3862.

Para obter assistência lingüística em português ligue para o 1-888-982-3862 gratuitamente.

Пентру асиstență lingvistică în românește telefoanți la numărul gratuit 1-888-982-3862

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-888-982-3862.

Mo fesoasoani tau gagana I le Gagana Samoa vala’au le 1-888-982-3862 e au no ma se tōtōgi.

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

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

Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero dōo 1-888-982-3862 Njodi woo fawaaki on.

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

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

1-888-982-3862 ငှါး မိန့် ငှါးမိန့် (တရားနှင့်)

สำหรับความช่วยเหลือทางด้านภาษาเป็นภาษาไทยโทร 1-888-982-3862 ฟรีไม่มีค่าใช้จ่าย

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

Ren ánninisín chiakú ren (Kapasen Chuuk) kopwe kēkkéérí 1-888-982-3862 nge esapw kamé ngonuk.

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

Щоб отримати допомогу перекладача української мови, зазаликоваєте за безкоштовним номером 1-888-982-3862.

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

Fərər Şefereh  التركي ای ایش روئن 1-888-982-3862 قری یون ایت پریا.

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