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](http://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/](https://www.healthcare.gov/sbc-glossary/) or call 1-800-370-4526 to request a copy.

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>Network: Individual $0 / Family $0. Out-of-Network: Individual $300 / Family $600. 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. 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><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. Emergency care is covered before you meet your deductible.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>No.</td>
</tr>
<tr>
<td><strong>for specific services?</strong></td>
<td>Network: Individual $7,150 / Family $14,300. You don't have to meet deductibles for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>Out-of-Network: Individual None / Family None.  The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums, balance-billing charges &amp; health care this plan doesn't cover. Even though you pay these expenses, they don't count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td><strong>Will you pay less if you use a network provider?</strong></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>
</tr>
</tbody>
</table>
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.

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></td>
<td></td>
<td>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 copay/visit, deductible doesn't apply</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$20 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; deductible doesn't apply to child immunizations; 20% coinsurance for prostate specific antigen tests &amp; digital rectal exams; well child &amp; adult routine physicals not covered</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>10% coinsurance, deductible doesn't apply</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% coinsurance, deductible doesn't apply</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>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>Copay/prescription, deductible doesn't apply: $7 (retail), $14 (mail order)</td>
<td>Not covered</td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at <a href="http://www.aetnapharmacy.com/premierplus">www.aetnapharmacy.com/premierplus</a></td>
<td>Preferred brand drugs</td>
<td>Copay/prescription, deductible doesn't apply: $15 (retail), $30 (mail order)</td>
<td>Not covered</td>
</tr>
<tr>
<td>Premier Plus Formulary</td>
<td>Non-preferred brand drugs</td>
<td>Copay/prescription, deductible doesn't apply: $40 (retail), $80 (mail order)</td>
<td>Not covered</td>
</tr>
<tr>
<td>Specialty drugs</td>
<td></td>
<td>Applicable cost as noted above for generic or brand drugs</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% coinsurance, deductible doesn't apply</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>10% coinsurance, deductible doesn't apply</td>
<td>30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$50 copay/visit, deductible doesn't apply</td>
<td>$50 copay/visit, deductible doesn't apply</td>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td>10% coinsurance, deductible doesn't apply</td>
<td>10% coinsurance, deductible doesn't apply</td>
<td>30% coinsurance for non-emergency transport.</td>
</tr>
<tr>
<td>Urgent care</td>
<td>$20 copay/visit, deductible doesn't apply</td>
<td>30% coinsurance</td>
<td>No coverage for non-urgent use.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% coinsurance, deductible doesn't apply</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>10% coinsurance, deductible doesn't apply</td>
<td>30% coinsurance</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>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td><strong>Outpatient services</strong></td>
<td>Office &amp; other outpatient services: $20 copay/visit, deductible doesn't apply</td>
<td>Office &amp; other outpatient services: 30% coinsurance</td>
</tr>
<tr>
<td></td>
<td><strong>Inpatient services</strong></td>
<td>10% coinsurance, deductible doesn't apply</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td><strong>Office visits</strong></td>
<td>No charge</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td><strong>Childbirth/delivery professional services</strong></td>
<td>10% coinsurance, deductible doesn't apply</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td><strong>Childbirth/delivery facility services</strong></td>
<td>10% coinsurance, deductible doesn't apply</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td><strong>Home health care</strong></td>
<td>No charge</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td><strong>Rehabilitation services</strong></td>
<td>10% coinsurance, deductible doesn't apply</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td><strong>Habilitation services</strong></td>
<td>10% coinsurance, deductible doesn't apply</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td><strong>Skilled nursing care</strong></td>
<td>10% coinsurance, deductible doesn't apply</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td><strong>Durable medical equipment</strong></td>
<td>10% coinsurance, deductible doesn't apply</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td><strong>Hospice services</strong></td>
<td>10% coinsurance, deductible doesn't apply</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>Not covered</td>
<td>Not covered</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:

<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>• Acupuncture</td>
</tr>
<tr>
<td>• Cosmetic surgery</td>
</tr>
<tr>
<td>• Dental care (Adult &amp; Child)</td>
</tr>
<tr>
<td>• Glasses (Child)</td>
</tr>
</tbody>
</table>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

| • Bariatric surgery                                       | • Chiropractic care - 20 visits/calendar year.     | • Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition. |

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/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 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.
- 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 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.
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 Standard? 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.-------------------
### 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 $20
- 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** $12,800

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

What isn’t covered $60

The total Peg would pay is $1,260

### 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 $20
- 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** $7,400

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>$800</td>
<td>$10</td>
<td></td>
</tr>
</tbody>
</table>

What isn’t covered $20

The total Joe would pay is $830

### Mia’s Simple Fracture (in-network emergency room visit and follow up care)
- The plan’s overall deductible $0
- Specialist copayment $20
- 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** $1,900

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>$90</td>
<td>$80</td>
<td></td>
</tr>
</tbody>
</table>

What isn’t covered $0

The total Mia would pay is $170

---

The **plan** would be responsible for the other costs of these EXAMPLE covered services.
Note: If your **plan** has a wellness program and you choose to participate, you may be able to reduce your costs.

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 1-800-370-4526.

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: 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 (Aetna).
TTY: 711

Language Assistance:

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

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-800-370-4526.
Amharic - እንግሪ እን한다면 ከ ከምርት ከ 1-800-370-4526 ያለ ይ. የ. ይ. ይ.
Arabic - للمساعدة في (اللغة العربية) الرجاء الاتصال على الرقم المجاني 1-800-370-4526.
Armenian - Հեղեք գույրքում պատասխանի (հայերեն) համար 1-800-370-4526 առանց գնով:
Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.
Bantul-Kirundi - Niba urondera uwugufashu mu Kirundi, twakure kuri iyi numero 1-800-370-4526 ku busa
Bengali-Bangala - বাংলা ভাষায় সাহায্য করার জন্য 1-800-370-4526 নম্বর থেকে কল করুন।
Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-370-4526 nga walay bayad.
Burmese - အင်္ဂါးများကို အခြေခံရန် 1-800-370-4526မှ အသုံးပြုပါသည်။
Catalan - Per rebrer assistència en (català), truqui al número gratuït 1-800-370-4526.
Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-800-370-4526 sin gástu.
Cherokee - ᎨᏦᏲᏧΘᏫᏲᎣᏫ.Ꭳ.ᏧᎣᏫ.ᎣᎣᏫ (GWA) ᎨᏨᏫ.Ꮼ.Ꮼ. 1-800-370-4526 ΟΘΤ Λ. ΑΓ. οΩΙ Δ. ΕΓΡ. Ι ΗΡΘ.
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 asitans nan lang Kreyòl Ayisyen, rele nimewo 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 γλώσσικη βοήθεια στα Ελληνικά καλέστε το 1-800-370-4526 χωρίς χρέωση.
Gujarati - આ ભાષામાં સહાય લોએ પણ 1-800-370-4526 વડો નંબરમાં.
Hawaiian - No ke kòkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-800-370-4526. Kāki ‘ole ‘ia kēia kòkua nei.

Hindi - कॉक्यू ना 1-800-370-4526 पर निर्देश मिलेंगे।

Hmong - Yob xav tuo kev pab txhais lus Hmoob hu dawb tao rau 1-800-370-4526.

Ibo - Maka enyemaka asusụ na Igbo kpọọ 1-800-370-4526 na akwụghị ụgwọ ọ bụla

Ilocano - Para iti tulong ti pagasasao iti pagasasao 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 まで無料で電話ください。

Karen - v\wfrRpRwfuwdRusd.ft*D>f usd.f ud; 1-800-370-4526 v\wtd.fD;wfv\mfbl.fv\mfphRb.f

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-370-4526번으로 전화해 주십시오.

Kurdish-Bassa - بە نی کە گبو-کپا-کپا دیە پیدیڕی دە BASOOW-WÇQUN WECE, دە 1-800-370-4526

Kurdish - برای راهنمایی به زبان فارسی با شماره 262-800-370-4526 یا به خزارتی پیاموندی بکار

Laotian - ບັ້ນພື້ນທະນາທິດ, ບັ້ນພື້ນທະນາທິດ 1-800-370-4526 ບັ້ນພື້ນທະນາທິດ.

Marathi - (शैक्षणिक) शैक्षणिक 1-800-370-4526

Marshallese - Ñan bök jipaŋ ilo Kajin Majol, kallok 1-800-370-4526 ilo eijelok wônän.

Micronesian-Pohnpeyan - Ohng palien sawas en soum kawewe ni omw lokaia Ponape koahl 1-800-370-4526 ni sohtes isais.

Mon-Khmer - អាវីកម្ពុជា 1-800-370-4526 ការចូលរួម

Navajo - T'áá shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíik'ë hólne' 1-800-370-4526

Nepali - 1-800-370-4526 को आपको अनुभव वाला है।

Nilotic-Dinka - Tên kuɔɔny ë thok ë Thuŋjāŋ col 1-800-370-4526 keçin ayoc.

Norwegian - For språkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt.

Panjabi - ਫ੍ਰੀਬੀਡ ਹਿੰਦੀ ਭਾਸ਼ੀ ਮਾਧਿਕਾ ਸਟੂਟੀ, 1-800-370-4526 ਦੇ ਮੁਫ਼ਤ ਬਾਸਤ ਬਚੇ।

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-800-370-4526 aa. Es Aaruf koschtet nix.

Persian - برای راهنمایی به زبان فارسی با شماره 262-800-370-4526 بدون هزینه آی تماس بگیرید. انگلیسی
Aby uzyskać 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 le Gagana Samoa vala‘au le 1-800-370-4526 e aunoa ma se totogi.

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

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

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

Kapau ‘oku fiema’u hā tokoni ‘i he lea faka-Tonga telefoni 1-800-370-4526 ‘o ‘ikai hā tōtōngi.

Ren ánínin sin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-800-370-4526 nge esapw kamé ngonuk.

(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-800-370-4526.

Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-370-4526.

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-800-370-4526.

Fún iránlọwọ nípa ëdè (Yorùbá) pe 1-800-370-4526 lái san owó kankan rará.