### Important Questions

<table>
<thead>
<tr>
<th><strong>What is the overall deductible?</strong></th>
<th><strong>Answers</strong></th>
<th><strong>Why This Matters:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>For each Plan Year, In-Network: Individual $0 / Family $0. Out-of-Network: Individual $400 / Family $800.</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>
<td></td>
</tr>
</tbody>
</table>

| **Are there services covered before you meet your deductible?** | Yes. Prescription drugs; plus in-network preventive care are covered before you meet your deductible. | This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |

| **Are there other deductibles for specific services?** | No. | You don’t have to meet deductibles for specific services. |

| **What is the out-of-pocket limit for this plan?** | In-Network: Individual $3,000 / Family $6,000. Out-of-Network: Individual $3,000 / Family $6,000. | The out–of–pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |

| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges, health care this plan doesn’t cover & penalties for failure to obtain pre-authorization for services. | Even though you pay these expenses, they don’t count toward the out–of–pocket limit. |

| **Will you pay less if you use a network provider?** | Yes. See www.aetna.com/docfind or call 1-877-480-4161 for a list of in-network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |

| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><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>$25 copay</td>
<td>30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$25 copay</td>
<td>30% coinsurance</td>
<td>None</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; immunizations up to age 19</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>00% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% coinsurance</td>
<td>00% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic drugs</td>
<td>Copay/prescription, deductible doesn't apply: $12 (retail)</td>
<td>30% coinsurance (retail)/prescription, deductible doesn't apply</td>
<td>Covers 30 day supply (retail), 31-90 day supply (retail); 3 copays per 90 day Supply. Includes contraceptive drugs &amp; devices obtainable from a pharmacy, oral &amp; injectable fertility drugs. No charge for preferred generic FDA-approved women’s contraceptives in-network. Review your formulary for prescriptions requiring precertification or step therapy for coverage.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>Copay/prescription, deductible doesn't apply: $40 (retail)</td>
<td>30% coinsurance (retail)/prescription, deductible doesn't apply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>Copay/prescription, deductible doesn't apply: $60 (retail)</td>
<td>30% coinsurance (retail)/prescription, deductible doesn't apply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Copay/prescription, deductible doesn't apply: $60 (retail)</td>
<td>30% coinsurance (retail)/prescription, deductible doesn't apply</td>
<td></td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</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>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>--------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td><strong>In-Network Provider</strong> (You will pay the least) $100 <strong>copay</strong></td>
<td>No coverage for non-emergency use. <strong>Copay</strong> waived if admitted.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No Charge</td>
<td>Non-emergency transport: not covered, except if pre-authorized.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td><strong>In-Network Provider</strong> (You will pay the least) $50 <strong>copay</strong></td>
<td>No coverage for non-urgent use.</td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td><strong>In-Network Provider</strong> (You will pay the least) 10% <strong>coinsurance</strong></td>
<td>Penalty of $500 for failure to obtain pre-authorization for out-of-network care.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td><strong>Out-of-Network Provider</strong> (You will pay the most) 30% <strong>coinsurance</strong></td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td><strong>In-Network Provider</strong> (You will pay the least) 10% <strong>coinsurance</strong></td>
<td>None</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td><strong>Out-of-Network Provider</strong> (You will pay the most) 30% <strong>coinsurance</strong></td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td><strong>In-Network Provider</strong> (You will pay the least) 0% <strong>coinsurance</strong></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) for which <strong>coinsurance</strong> may apply.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td><strong>Out-of-Network Provider</strong> (You will pay the most) 30% <strong>coinsurance</strong></td>
<td>None</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td><strong>Out-of-Network Provider</strong> (You will pay the most) 30% <strong>coinsurance</strong></td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td><strong>In-Network Provider</strong> (You will pay the least) $25 <strong>copay</strong>, deductible doesn't apply</td>
<td>40 visits/year</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td><strong>Out-of-Network Provider</strong> (You will pay the most) 30% <strong>coinsurance</strong></td>
<td>60 visits/year. Includes physical, occupational therapy and speech.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td><strong>Out-of-Network Provider</strong> (You will pay the most) 30% <strong>coinsurance</strong></td>
<td>None</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td><strong>Out-of-Network Provider</strong> (You will pay the most) 30% <strong>coinsurance</strong></td>
<td>Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td><strong>Out-of-Network Provider</strong> (You will pay the most) 30% <strong>coinsurance</strong></td>
<td>210 Day limit; unlimited family bereavement counseling.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td><strong>Out-of-Network Provider</strong> (You will pay the most) 30% <strong>coinsurance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
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<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>
<td></td>
</tr>
<tr>
<td>Children's eye exam</td>
<td>No Charge</td>
<td>No charge</td>
<td>1 routine eye exam/plan year up to age 19.</td>
<td></td>
</tr>
<tr>
<td>Children's glasses</td>
<td>50% coinsurance, deductible doesn't apply</td>
<td>50% coinsurance, after deductible</td>
<td>1 pair of glasses/plan year (lenses and frames); maximum of $200 benefit for frames</td>
<td></td>
</tr>
<tr>
<td>Children's dental check-up</td>
<td>No charge</td>
<td>No charge</td>
<td>None</td>
<td></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)
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- 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
- Bariatric surgery
- Chiropractic care
- Hearing aids - 1 hearing aid per ear/per plan year.
- Non-emergency care when traveling outside the U.S.
- Medical Evacuation and Repatriation

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: Department of Financial Services, Consumer Assistance Unit, 800-342-3736, [http://www.dfs.ny.gov/consumer/fileacomplaint.htm](http://www.dfs.ny.gov/consumer/fileacomplaint.htm).

- For more information on your rights to continue coverage, contact the plan at 1-877-480-4161.
- State Consumer Assistance Program, if other than state insurance department 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/](http://www.communityhealthadvocates.org/).
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 1-877-480-4161.
- 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.
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 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** $12,800

<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>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,260</td>
</tr>
</tbody>
</table>

**What isn't covered**
- Limits or exclusions $60

The total Peg would pay is $1,320

### 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: $25
- 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></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$50</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$780</td>
</tr>
</tbody>
</table>

**What isn't covered**
- Limits or exclusions $60

The total Joe would pay is $890

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

- The plan's overall deductible: $0
- Specialist coinsurance: 0%
- Hospital (facility) coinsurance: 0%
- Other coinsurance: 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

<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>$200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$30</td>
</tr>
</tbody>
</table>

**What isn't covered**
- Limits or exclusions $0

The total Mia would pay is $230

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 1-877-480-4161.

**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.**
TTY: 711

Language Assistance:

For language assistance in your language call 1-877-480-4161 at no cost.

Albanian - Për asistencia e gjëshës sëbançës të telefononit falas të 1-877-480-4161.
Amharic - ከማርኛ እስከ ከማርኛ ከ 1-877-480-4161 በቀዳማዊ ከማርኛ
Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-877-480-4161.
Armenian - Հետախուզական օգնության (հայերեն) համար 1-877-480-4161 հաշվով գնել:
Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-877-480-4161 tanpa dikenakan biaya.
Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-877-480-4161 ku busa
Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-877-480-4161-তে কল করুন।
Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-877-480-4161 nga walay bayad.
Burmese - ၽမီးကြည်မှုအများစုဗား (အမေရိက်) သို့ 1-877-480-4161 နောက်ခံစီး
Catalan - Per rebre assistència en (català), truqui al número gratuït 1-877-480-4161.
Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-877-480-4161 sin gástu.
Cherokee - ᎣᏍᎩ ᎣᏍᎢᏗ ᎣᏍᏗᏍᎳᏘ ᎫᏘᏴ Nineteen 1-877-480-4161 ᏣᏍᎦᏘكرة ᏣᏍᏗᏗᏗᏝΕhawks.
Chinese - 欲取得繁體中文語言協助，請撥打 1-877-480-4161，無需付費。
Choctaw - (Chahta) anumpa ya apela a chi l paya hinla 1-877-480-4161.
Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuuf lakkokkofsa bilbilaa 1-877-480-4161 irratti bilisaan bilbilaa.
Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-877-480-4161.
French - Pour une assistance linguistique en français appeler le 1-877-480-4161 sans frais.
French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-877-480-4161 gratis.
German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-877-480-4161 an.
Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-877-480-4161 χωρίς χρέωση.
Gujarati - ગુજરાતીમાં સહાય માટે હાઇ પાસ અર્થ વગર 1-877-480-4161 પર કોલ કરો.
Hindi - हिन्दी में भाषा सहायता के लिए, 1-877-480-4161 पर मुफ्त कॉल करें।
Hmong - Maka enyemaka asusu na Igbo kpoŋ 1-877-480-4161 na akwughí ugwọ ọ bụla
Ibo - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-877-480-4161 nga awan ti bayadanyo.
Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-877-480-4161 nga awan ti bayadanyo.
Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-877-480-4161.
Japanese - 日本語で援助をご希望の方は、1-877-480-4161まで無料でお電話ください。
Karen - သီးခြားကွဲ မိုးမျှော် သိမ်းဆောင်မှု 1-877-480-4161 ကို တင်ပြောပါ။
Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-877-480-4161 번으로 전화해 주십시오.
Kru-Bassa - Be’m ké gbo-kpá-kpá dyé pidyi dë Basso-wuˈquün wèe, dà 1-877-480-4161
Kurdish - 1-877-480-4161
Laotian - 1-877-480-4161
Marathi - तीलभाषा (मराठी) सहाय्यासाठी 1-877-480-4161 क्रमांकावरकोणत्याहीखपूर्वीशिवायकोलकरा.
Marshallese - Ñan bōk jipaŋ ilo Kajin Majol, kallok 1-877-480-4161 ilo ejjelok wōnān.
Micronesian-Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-877-480-4161 ni sohte isais.
Mon-Khmer, Cambodian - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-877-480-4161 ni sohte isais.
Navajo - T'áá shi shizaad k'ehjí bee shiká a'doowol nínízingo Diné k'ehjí koji' t'áá jiik'e hólne' 1-877-480-4161
Nepali - (लेपाली) मा निश्चल भाषा सहायता पाउनका लागि 1-877-480-4161 मा फोन गर्नु होस्।
Nilotic-Dinka - Tën kuony é thok ê Thuoŋján çol 1-877-480-4161 kecín ayóc.
Norwegian - For språkassistanse på norsk, ring 1-877-480-4161 kostnadsfritt.
Panjabi - ਪੰਜਾਬੀ ਹਿੰਦੂ ਭਾਸ਼ਾ ਪ੍ਰਿਸਟੇਨਕ ਲਾਗਨ ਦੀ ਤਕਨੀਕ 1-877-480-4161 ਕਰੀਂ ਮੁਫ਼ਤ ਕਲਸਿਲ ਵਲੇ।
Persian - برای راهنمایی به زبان فارسی با شماره 1-877-480-4161 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-877-480-4161.
Para obter assistência linguística em português ligue para o 1-877-480-4161 gratuitamente.

Pentru asistență lingvistică în română, telefonați la numărul gratuit 1-877-480-4161.

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-877-480-4161.

Mo fesoasoani tau gagana le Gagana Samoa vala’au le 1-877-480-4161 e aunoa ma se totogi.

Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-877-480-4161.

Para obtener asistencia lingüística en español, llame sin cargo al 1-877-480-4161.

Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-877-480-4161. Njodi woo fawaaki on.

Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-877-480-4161 bila malipo.

Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-877-480-4161 nang walang bayad.

Para obtener asistencia lingüística en español, llame sin cargo al 1-877-480-4161.

Kapau ‘oku fiema’u hā tokoni ‘i he lea faka-Tonga telefoni 1-877-480-4161 ‘o ‘ikai hā ʻōtōngi.

Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-877-480-4161 nge esapw kamé ngonuk.

(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-877-480-4161.

Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-877-480-4161.

DE DƯỚC HỖ TRỢ NGỎ NGỮ BẰNG (NGÔN NGỮ), HAY GỌI MIỄN PHÍ DỄ SỞ 1-877-480-4161.

Fún irànlwọ nípa èdè (Yorùbá) pe 1-877-480-4161 lái san owó kankan rárá.