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 1-855-856-0038. 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 1-855-856-0038 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>For each Plan Year, In-Network: Individual $750/ each individual must meet the individual deductible.</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><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. Prescription drugs; plus in-network preventive care 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><strong>Are there other deductibles for specific services?</strong></td>
<td>Per your plan there are other specific deductibles. Please refer to your Summary Plan Description for this information.</td>
<td>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>In-Network: Individual $1,500 / Family $3,000. Out-of-Network: Individual $4,500 / Family $9,000.</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, 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, penalties for failure to obtain pre-authorization for services &amp; health care this plan doesn’t cover.</td>
<td>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 In-Network providers?</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td><strong>Do you need a referral to see a specialist?</strong></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>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>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% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>40% coinsurance</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.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>Deductible doesn’t apply, 30 day supply: $12.50, 90 day supply: $25.00</td>
<td>Deductible doesn’t apply, 30 day supply: $12.50, less the negotiated in-network discount</td>
<td>Covers 30 day supply (retail), 61-90 day supply (mail order/maintenance). Your plan uses a preferred drug list which identifies the status of covered drugs. Some drugs may required pre-authorization. If necessary pre-authorization is not obtained, the drug may not be covered. Certain items identified by your plan as preventive care are covered in full not subject to the copayment amount indicated. You pay the difference in cost if you request a brand name drug instead of its generic equivalent plus the copayment.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>Deductible doesn’t apply, 30 day supply: $25.00, 90 day supply: $50.00</td>
<td>Deductible doesn’t apply, 30 day supply: $25.00, less the negotiated in-network discount</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>Deductible doesn’t apply, 30 day supply: $50.00, 90 day supply: $100.00</td>
<td>Deductible doesn’t apply, 30 day supply: $50.00, less the negotiated in-network discount</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Deductible doesn’t apply, 30 day supply: $100.00, 90 day supply: $200.00</td>
<td>Deductible doesn’t apply, 30 day supply: $100.00, less the negotiated in-network discount</td>
<td>None</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay In-Network Provider (You will pay the least)</td>
<td>What You Will Pay Out-of-Network Provider (You will pay the most)</td>
<td>Limitations, Exceptions &amp; Other Important Information</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>20% coinsurance after $400 copay/visit</td>
<td>20% coinsurance after $400 copay/visit</td>
<td>$400/visit for in-network &amp; out-of-network emergency room visit. Per visit co-pay is waived if admitted.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance after $250 copay/stay</td>
<td>40% coinsurance after $500 copay/stay</td>
<td>$250/admission for in-network hospital stay, $500/admission for out-of-network hospital stay. Pre-authorization required for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office &amp; other outpatient services: 20% coinsurance</td>
<td>Office &amp; other outpatient services: 40% coinsurance</td>
<td>Mental Health &amp; Substance Abuse benefits not provided by Aetna. Contact Magellan 800-513-2611</td>
</tr>
<tr>
<td>Coverage for these services administered by Magellan Health or call 1-800-513-2611.</td>
<td>Inpatient services</td>
<td>20% coinsurance after $250 copay/stay</td>
<td>40% coinsurance after $500 copay/stay</td>
<td>$250/admission for in-network hospital stay, $500/admission for out-of-network hospital stay.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>20% coinsurance</td>
<td>40% 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.) $250/admission for in-network hospital stay, $500/admission for out-of-network hospital stay. Pre-authorization required for out-of-network care may apply.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance after $250 copay/stay</td>
<td>40% coinsurance after $500 copay/stay</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Custodial care not covered. Pre-authorization required for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay In-Network Provider (You will pay the least)</td>
<td>What You Will Pay Out-of-Network Provider (You will pay the most)</td>
<td>Limitations, Exceptions &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------------------------------------------------</td>
<td>--------------------------------------------------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
<td>100 days/annual max. Custodial care not covered. Pre-authorization required for out-of-network care.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
<td>Pre-authorization required for out-of-network care.</td>
</tr>
</tbody>
</table>

**If your child needs dental or eye care**

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Children's eye exam</td>
<td>Not covered</td>
<td>Not covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children's glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children's dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td></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.)**

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Habilitation services
- Hearing aids
- Long-term care
- Private-duty nursing
- 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 - 30 visits/plan year.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Non-emergency care when traveling outside the U.S.

**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 1-855-856-0038.
- 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 1-855-856-0038.
• 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:

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.-------------------
**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: $750
- Specialist Coinsurance: 20%
- Hospital (facility) Coinsurance: 20%
- Other Coinsurance: 20%

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)

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$12,800</th>
</tr>
</thead>
</table>

In this example, Peg would pay:

| Cost Sharing | 
|----------|---------|
| Deductibles | $800 |
| Copayments | $0 |
| Coinsurance | $800 |

What isn’t covered

- Limits or exclusions: $60
- The total Peg would pay is: $1,660

---

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

- The plan’s overall deductible: $750
- Specialist Coinsurance: 20%
- Hospital (facility) Coinsurance: 20%
- Other Coinsurance: 20%

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)

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$7,400</th>
</tr>
</thead>
</table>

In this example, Joe would pay:

| Cost Sharing | 
|----------|---------|
| Deductibles | $800 |
| Copayments | $700 |
| Coinsurance | $70 |

What isn’t covered

- Limits or exclusions: $20
- The total Joe would pay is: $1,590

---

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

- The plan’s overall deductible: $750
- Specialist Coinsurance: 20%
- Hospital (facility) Coinsurance: 20%
- Other Coinsurance: 20%

This EXAMPLE event includes services like:
- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$1,900</th>
</tr>
</thead>
</table>

In this example, Mia would pay:

| Cost Sharing | 
|----------|---------|
| Deductibles | $800 |
| Copayments | $0 |
| Coinsurance | $200 |

What isn’t covered

- Limits or exclusions: $0
- The total Mia would pay is: $1,000

---

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: 1-855-856-0038.

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 1-855-856-0038.

**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: 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 1-855-856-0038 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-855-856-0038.
Amharic - እስከት እንወ ይ ኣማርኛ እየ እንወ 1-855-856-0038 ይ ኣማርኛ.
Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-855-856-0038.
Amenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-855-856-0038 առանց գնով:
Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-855-856-0038 tanpa dikenakan biaya.
Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure khiyamurikyo 1-855-856-0038 kwo busa
Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিএনমাছোল্য 1-855-856-0038-তে কল করুন।
Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-855-856-0038 nga walay bayad.
Burmese - 1-855-856-0038 ၏ ၎င်းပြည်သူ့လိုအသွားအပြုမှု၏
Catalan - Per rebre assistència en (català), truqui al número gratuït 1-855-856-0038.
Chamorro - Para ayuda gi fino (Chamoru), ågang 1-855-856-0038 sin gástu.
Cherokee - ᓀᐦᐃᔭᐍᐣ ᓃᐱ ᓃᐱ ᓃᐱ ᓃᐱ ᓃᐱ ᓃᐱ ᓃᐱ ᓃᐱ ᓃᐱ ᓃᐱ ᓃᐱ ᓃᐱ ᓃᐱ ᓃᐱ ᓃᐱ ᓃᐱ ᓃᐱ ᓃᐱ ᓃᐱ ᓃᐱ ᓃᐱ ᓃᐱ ᓃᐱ ᓃᐱ ᓃᐱ ᓃᐱ ᓃᐱ ᓃᐱ ᓃᐱ ᓃᐱ ᓃᐱ ᓃᐱ ᓃᐱ ᓃᐱ ᓃᐱ ᓃᐱ ᓃᐱ ᓃᐱ ᓃᐱ ᓃᐱ ᓃᐱ ᓃᐱ ᓃᐱ ᓃᐱ ᓃᐱ ᓃDICP.1 hFRO.1
Chinese - 欲取得繁體中文語言協助，請撥打 1-855-856-0038，無需付費。
Choctaw - (Chahta) anumpa ya apela a chi l paya hinla 1-855-856-0038.
Cushite - Gargaarsa afana Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-855-856-0038 irratti bilisaan bilbilaa.
Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-855-856-0038.
French - Pour une assistance linguistique en français appeler le 1-855-856-0038 sans frais.
French Creole - Pou jwenn asitans nan lang Kreyòl Ayisyen, rele nimewo 1-855-856-0038 gratis.
German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-855-856-0038 an.
Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-855-856-0038 χωρίς χρέωση.
Gujarati - ગુજરાતીમાં ભાષા સહાય માટ કોઈ પણ અર્થ વગર 1-855-856-0038 પર કોલ કરો.

Hindi - हिन्दी में भाषा सहायता के लिए, 1-855-856-0038 पर मुफ्त कॉल करें।

Hmong - Maka enyemaka asusû na Igbo kpoo 1-855-856-0038 na akwughî ugwọ o bula

Ibo - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-855-856-0038 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-855-856-0038.

Japanese - 日本語で援助をご希望の方は、1-855-856-0038 まで無料でお電話ください。

Karen - 1-855-856-0038

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

Kurdish - 1-855-856-0038

Laotian - 1-855-856-0038

Marathi - तीलभाषा (मराठी) सहायता पाऊनका क्रमांकावरकोण्टयाही शिवाय कॉल करा.

Marshallese - Ñan bōk jipaĩ ilo Kajin Majol, kallok 1-855-856-0038 ilo ejjelok wönân.

Micronesian-Pohnpeyan - Ohng palien sawas en souk kawewe ni omw lokaia Ponape koahl 1-855-856-0038 ni sohte isais.

Mon-Khmer, Cambodian - 1-855-856-0038

Navajo - T'áá shi shaad k'ehjí bee shiká a'doowol nínízingo Diné k'ehjí koji' t'áá jiik'e hólne' 1-855-856-0038

Nepali - (नेपाली) मा नि:शुल्क भाषा सहायता पाउनका लागि 1- 855-856-0038 मा फोन गर्नुहोस्।

Nilotic-Dinka - Tën kuunny è thok è Thuonjjan col 1-855-856-0038 kecin ayoc.

Norwegian - For språkassistanse på norsk, ring 1-855-856-0038 kostnadsfritt.

Panjabi - ਫੇਸ਼ਲੀ ਹਿੰਦੀ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਲਾਂਝੀ 1-855-856-0038 ਦੇ ਫੋਨ ਵਰਤੋਂ ਵੇਲੇ।


Persian - برای راهنمايي به زبان فارسي با شماره 1-855-856-0038 بدون هزینه ای تماس بگیرید.

Polish - Aby uzyskać pomoc w języku polskim, zadźwoń bezpłatnie pod numer 1-855-856-0038.
Para obter assistência linguística em português ligue para o 1-855-856-0038 gratuitamente.

Pentru asistență lingvistică în română lăsați telefonul la numărul gratuit 1-855-856-0038.

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-855-856-0038.

Mo fesoasoani tau gagana l le Gagana Samoa vala'au le 1-855-856-0038 e aunoa ma se totogi.

Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-855-856-0038.

Para obtener asistencia lingüística en español, llame sin cargo al 1-855-856-0038.

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Fii yo on hebu balal e ko yowitii e haalaa Pular noddee e oo numero doo 1-855-856-0038. Njodi woo fawaaki on.

Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-855-856-0038 bila malipo.

Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-855-856-0038 nang walang bayad.

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Kapau ‘oku fiema’u hä tokoni ‘i he lea faka-Tonga telefoni 1-855-856-0038 ‘o ‘ikai hā ʻōtōngi.

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Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-855-856-0038 nge esapw kamé ngonuk.

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(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-855-856-0038.

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Việt Nam - Để được hỗ trợ ngôn ngữ (ngôn ngữ), hãy gọi miễn phí đến số 1-855-856-0038.

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Fún iránlọwọ nípa èdè (Yorùbá) pe 1-855-856-0038 lái san owó kankan rárá.