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.aetnasastateofillinois.com/health-plans](https://www.aetnasastateofillinois.com/health-plans) 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/](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>What is the overall deductible?</td>
<td>$1,000 per enrollee.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. In-network preventive care is covered before you meet your deductible.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>Yes. $350 per in-network hospital admission; $600 per out-of-network hospital admission; $400 per emergency room visit; $250 for organ and tissue transplants; $175 for prescription drugs.</td>
<td>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.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>In-Network: Individual $2,000 / Family $4,000. Out-Of-Network: Individual $6,000 / Family $12,000.</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>What is not included in the out-of-pocket limit?</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>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-800-370-4526 for a list of 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>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>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>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>50% 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>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Requires pre-authorization. If necessary pre-authorization is not obtained, benefits may be reduced or not covered.</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>30 day supply: $15.00; 90 day supply: $30.00</td>
<td>30 day supply: $15.00*; 90 day supply: $30.00* *Plus difference between retail cost and in-network price</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 require 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. If drugs are purchased at out-of-network pharmacy, you must pay the full retail cost at time of purchase and request reimbursement of eligible charges by submitting a paper claim to CVS/caremark.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>30 day supply: $30.00; 90 day supply: $60.00</td>
<td>30 day supply: $30.00*; 90 day supply: $60.00* *Plus difference between retail cost and in-network price</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>30 day supply: $60.00; 90 day supply: $120.00</td>
<td>30 day supply: $60.00*; 90 day supply: $120.00* *Plus difference between retail cost and in-network price</td>
<td></td>
</tr>
</tbody>
</table>

**More information about prescription drug coverage** is available at www.caremark.com or call 1-877-232-8128.
<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>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>Specialty drugs</td>
<td></td>
<td>30 day supply: $120.00; 90 day supply: $240.00</td>
<td>30 day supply: $120.00*; 90 day supply: $240.00* *Plus difference between retail cost and in-network price</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>20% coinsurance</td>
<td>20% coinsurance, Per visit deductible is waived if admitted.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>50% coinsurance, Pre-authorization required for out-of-network care. If pre-authorization is not obtained, benefits may be reduced or not covered.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>---------------------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>Not covered</td>
<td>Not covered</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:

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
- Custodial care
- Dental care
- Hearing aids
- Long-term care
- Private-duty nursing
- Routine eye care
- 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.)
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:
• Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565 or www.cciio.cms.gov.
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 by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-855-856-0038; or
• Illinois Department of Central Management Services, Group Insurance Division, at 1-800-442-1300 or by email at CMS.Ben.BCS@illinois.gov.

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan Meet Minimum Value Standard? No.
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.

---

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe's type 2 Diabetes</th>
<th>Mia's Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(9 months of in-network pre-natal care and a hospital delivery)</strong></td>
<td><strong>(a year of routine in-network care of a well-controlled condition)</strong></td>
<td><strong>(in-network emergency room visit and follow up care)</strong></td>
</tr>
</tbody>
</table>

- **The plan's overall deductible**: $1,000
- **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)

**Total Example Cost**: $12,800

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles*</td>
<td>$1,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,348</td>
</tr>
</tbody>
</table>

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

The total Peg would pay is $3,408

---

This EXAMPLE event includes services like:
- Primary care physician office visits (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs
- Durable medical equipment (glucose meter)

**Total Example Cost**: $7,400

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles*</td>
<td>$1,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,276</td>
</tr>
</tbody>
</table>

What isn't covered:
- Limits or exclusions $20

The total Joe would pay is $2,296

---

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

**Total Example Cost**: $1,900

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles*</td>
<td>$1,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$180</td>
</tr>
</tbody>
</table>

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

The total Mia would pay is $1,180

---

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.

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

*Note: Your deductible may be different than the examples depending on your annual salary. For your applicable deductible, see page 1 of this document.

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: CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).
TTY: 711

Language Assistance:

For language assistance in your language call 1-855-856-0038 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-855-856-0038.
Amharic - እንዳንዬ ከማ እናን መስገቅ መለስ እና 1-855-856-0038 የተ ያጋ ይት.
Arabic - لمساعدتكم في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-855-856-0038.
Armenian - Այսօր գնդակառավարեք պահանջումների (համարը) համար 1-855-856-0038 կարող զինգի: 855-866-0038
Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-855-856-0038 tanpa dikenakan biaya.
Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-855-856-0038 ku busa
Bengali-Bangala - বাংলা ভাষা সহায়তার জন্য বিনামূল্যে 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 - မြန်မာနိုင်ငံ မှ ပြင်သော ပြည်သူများ အားလုံး 1 855-856-0038
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 - ᎣᎦᏯᏣᏗ Ꭻ�一直在 ᎣᎦᏯᏣᏗ ᎯᏣᏗᏲ (GWW) ᎩᏗᏣᏲ 1-855-856-0038 ᎢΘᏮ Ꭴ ᎤᏏ ᏪᏤᏗ Ꮵ ᏤᏗᏲ.
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 afaaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-855-856-0038 irratti bilisanaa 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 jwen asistans 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 - ગુજરાતીમા લાગણી સહાય માટે કોઈ પણ વગર 1-855-856-0038 પર કોલ કરો.
Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-855-856-0038. Kākī ‘ole ‘ia kēia kōkua nei.

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

Hmong - Maka enyemaka aŋsú na Igbo kpoŋ 1-855-856-0038 na akwýghi ūgwọ ọ bula

Ilocano - 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 - Be’m ké gbo-kpá-kpá dyé pidyi dë Basso-wuqúun wée, dë 1-855-856-0038

Kurdish - 1-855-856-0038

Laotian - Nhán bôk jìpañ ilo Kajin Majol, kallok 1-855-856-0038 ilo ejelok wónān.

Marathi - तीलभाषा (मराठी) सहाय्यासाठी 1-855-856-0038 क्रमांकांकावर कोणत्याहीखर्चांचे विवेकानिवेच्या कॉललेक्टरा.

Marshallese - Ñan bôk jìpañ ilo Kajin Majol, kallok 1-855-856-0038 ilo ejelok wónān.

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

Mon-Khmer - 1-855-856-0038

Navajo - T'áá shíi shíi k'ehjí bee shiká a'doowol níní úm Diné k'ehjí k'oojí t'áá jíik'e hólne' 1-855-856-0038

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

Nilotic-Dinka - Tën kuonny ê thok ê Thuonjân cãl 1-855-856-0038 kecin ayôc.

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

Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਇ ਸਹਾਇਤਾ ਪੈਂਟੀ ਲਾਗੀ 1-855-856-0038 ਮਾ ਫੋਨ ਗਨਨੌਸ।


Persian - برای راهنمایی به زبان فارسی با شماره 1-855-856-0038 بدون هیچ هزینه ای تماس بگیرید. انگلیسی

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń 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 românește telefonați la numărul gratuit 1-855-856-0038.

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

Mo fesoasoani tau gagana le Gagana Samoa val’a’au le 1-855-856-0038 e aunoa ma se totoni.

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.

Fii yo on hebu balal e ko yowittie e haala 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.

สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-855-856-0038 ฟรีไม่มีค่าใช้จ่าย.

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

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

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

Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-855-856-0038.

珍珠語 Kal Koea M Rib 1-855-856-0038 ngon ngu dang (ngon ngu), hay goi miên phi’deén só’1-855-856-0038.

Før eller húrla ła’la (Yorùbá) pe 1-855-856-0038 lái san owó kankan rárá.