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, go to [http://www.mcclatchylivewell.com/](http://www.mcclatchylivewell.com/) or by calling 1-888-982-3862. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [https://www.healthcare.gov/sbc-glossary/](https://www.healthcare.gov/sbc-glossary/) or call 1-888-982-3862 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>Network: EE Only $2,000; EE+Spouse/Child(ren) $4,000; EE+Family $6,000. Out-of-Network: EE Only $3,300; EE+Spouse/Child(ren) $4,950; EE+Family $6,600.</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. 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><strong>Are there other deductibles for specific services?</strong></td>
<td>No.</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>Network: EE Only $5,000; EE+Spouse/Child(ren) $7,500; EE+ Family $10,000. Out-of-Network: Individual $6,350; EE+Spouse/Child(ren) $9,525; EE+Family $12,700.</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, health care this plan doesn’t cover &amp; penalties for failure to obtain pre-authorization for services.</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 1-888-982-3862 for a list of 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>What You Will Pay</th>
<th>Limitations, Exceptions &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>Network Provider (You will pay the least): 20% coinsurance; Out-of-Network Provider (You will pay the most): 40% coinsurance</td>
<td>Includes internal medicine, general practice, family practice and pediatrics.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>20% coinsurance; 40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care / screening / immunization</td>
<td>No charge; No charge</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. Age and frequency limits may apply.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% coinsurance; 40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance; 40% 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>After deductible: 20% coinsurance; Not covered</td>
<td>Covers 30 day supply (retail), 31-90 day supply (retail or mail order). Review your formulary for prescriptions requiring precertification or step therapy.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>After deductible: 20% coinsurance; Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>After deductible: 20% coinsurance; Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>After deductible: 20% coinsurance; Not covered</td>
<td>First prescription must be filled at a participating retail pharmacy or CVS Specialty Pharmacy. Subsequent fills must be through CVS Specialty Pharmacy.</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance; 40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance; 40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care</td>
<td>20% coinsurance; 20% coinsurance</td>
<td>No coverage for non-emergency use.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% coinsurance; 20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>20% coinsurance; 40% coinsurance</td>
<td>None</td>
</tr>
</tbody>
</table>

More information about **prescription drug coverage** is available at [www.caremark.com](http://www.caremark.com).
<table>
<thead>
<tr>
<th>If you have a hospital stay</th>
<th>Facility fee (e.g., hospital room)</th>
<th>20% coinsurance</th>
<th>40% coinsurance</th>
<th>Penalty of $250 for failure to obtain pre-authorization for out-of-network care.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>40% coinsurance</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>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Penalty of $250 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td>Inpatient services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>40% coinsurance</td>
<td>Cost sharing doesn't apply to certain preventive services. Maternity care may include tests &amp; services described elsewhere in the SBC (i.e. ultrasound). Includes outpatient postnatal care. Penalty of $250 for failure to obtain pre-authorization for out-of-network care may apply.</td>
</tr>
<tr>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</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>40% coinsurance</td>
<td>Coverage is limited to 120 visits/calendar year. Penalty of $250 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Habilitation services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Limited to children up to age 6 for neurodevelopmental therapy.</td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Coverage is limited 100 days/calendar year. Penalty of $250 for failure to obtain pre-authorization for out-of-network care.</td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Hospice services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Penalty of $250 for failure to obtain pre-authorization for out-of-network care.</td>
<td></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>
<td>Not covered.</td>
</tr>
<tr>
<td>Children's glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Children's dental check-up</td>
<td>Not covered</td>
<td>Not covered</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</th>
<th>Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Cosmetic surgery</td>
<td>- Hearing aids - 1 hearing aid to $1,000 maximum/24 months for children up to age 19 &amp; 1 hearing aid to $1,000 maximum/36 months thereafter.</td>
</tr>
<tr>
<td>- Dental care (Adult &amp; Child)</td>
<td>- Infertility treatment - Limited to the diagnosis &amp; treatment of underlying medical condition.</td>
</tr>
<tr>
<td>- Glasses (Child)</td>
<td></td>
</tr>
<tr>
<td>- Long-term care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Acupuncture - 12 visits/calendar year.</td>
</tr>
<tr>
<td></td>
<td>- Bariatric surgery - $5,000 maximum/lifetime for in-network only.</td>
</tr>
<tr>
<td></td>
<td>- Chiropractic care - 20 visits/calendar year.</td>
</tr>
<tr>
<td></td>
<td>- Weight loss programs - Except for required preventive services.</td>
</tr>
<tr>
<td></td>
<td>- Routine eye care (Adult &amp; Child)</td>
</tr>
<tr>
<td></td>
<td>- Routine foot care.</td>
</tr>
</tbody>
</table>

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

- Acupuncture - 12 visits/calendar year.
- Bariatric surgery - $5,000 maximum/lifetime for in-network only.
- Chiropractic care - 20 visits/calendar year.
- Hearing aids - 1 hearing aid to $1,000 maximum/24 months for children up to age 19 & 1 hearing aid to $1,000 maximum/36 months thereafter.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Private-duty nursing - 70-8-hour shifts/calendar year.

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 1-888-982-3862.
- 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.

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 1-888-982-3862.
- 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.

- 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.------------------
### 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: $2,000
- 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>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$2,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,600</td>
</tr>
</tbody>
</table>

**What isn’t covered**

<table>
<thead>
<tr>
<th>Limits or exclusions</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$60</td>
</tr>
</tbody>
</table>

**The total Peg would pay is:** $3,660

---

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

- The plan's overall deductible: $2,000
- 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)

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

**In this example, Joe would pay:**

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

**What isn’t covered**

<table>
<thead>
<tr>
<th>Limits or exclusions</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$60</td>
</tr>
</tbody>
</table>

**The total Joe would pay is:** $3,060

---

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

- The plan's overall deductible: $2,000
- 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)

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

**In this example, Mia would pay:**

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

**What isn’t covered**

<table>
<thead>
<tr>
<th>Limits or exclusions</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$0</td>
</tr>
</tbody>
</table>

**The total Mia would pay is:** $1,900

---

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 1-888-982-3862.

**Smartphone or Tablet**
To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

**Non-Discrimination**
Aetna complies with applicable Federal civil rights laws and does not 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 1-888-982-3862 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-888-982-3862.

Amharic - እንወቻ ከወ ከ እንወቻ ት ከ 1-888-982-3862 የቹ ዘ.ወ.ቻ.

Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-888-982-3862.

Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-888-982-3862 առանց գնով.

Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya.

Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-888-982-3862 ku busa

Bengali-Bangala - বাংলা ভাষায় সহায়তা জন্য বিনামূল্য 1-888-982-3862-তে কল করুন।

Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-982-3862 nga walay bayad.

Burmese - ဗိုလ် ကုန်ကျင်ပါ၀ိုင် (မန္မာဘာသာစကာာ) ဖြူ ဘာသာစကာာအကူအညီရယူရနိုင်ပါ။ 1-888-982-3862 ကု ခၚဆ ုပါ။

Catalan - Per rebrir assistència en (català), truqui al número gratuït 1-888-982-3862.

Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-888-982-3862 sin gaustu.

Cherokee - ႏᎣᏍᎩᏍᎦᏲᏪᏤ ᎠᏤᏲᎦ.ᎣᏰᏫᏤ ᎢᏤ (GWW) ᐕᏫᎦᏣᏲ 1-888-982-3862 ᎨᏝᏣ Ꭿ ᎣᎦᏣ.Ꮽ.Ꮳ ᎨᎣ.Ꮷ.Ꮳ.

Chinese - 欲取得繁體中文語言協助，請撥打 1-888-982-3862，無需付費。

Choctaw - (Chahta) anumpa ya apela a chi l'paya hinla 1-888-982-3862.

Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkoofsa bilbilaa 1-888-982-3862 irratti bilisaan bilbilaa.

Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-888-982-3862.

French - Pour une assistance linguistique en français appelez le 1-888-982-3862 sans frais.

French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-982-3862 gratis.

German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-982-3862 an.

Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-982-3862 χωρίς χρέωση.

Gujarati - ગુજરાતીમાં લાભામાં સહાય માટે કોઈ પણ ભરાય વગર 1-888-982-3862 પર કોલ કરો.

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

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

Ibo - Maka enyemaka asusu na Igbo kpog 1-888-982-3862 na akwughị ugwọ ọ bụla

Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-982-3862 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-982-3862.

Japanese - 日本語で援助をご希望の方は、1-888-982-3862 まで無料でお電話ください。

Karen - v>w>frRp>Rw>fuwdRusd.ft*D>f usd.f ud; 1-888-982-3862 v>wtD;w>vfw>mfbl.fv>mfphRb.f

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

Kru-Bassa - Bë rin ké gbo-kpá-kpá dyé pidyi dé Básóó-wúdqún wëe, dë 1-888-982-3862

Kurdish - برای راهنمایی به زبان فارسی، با شماره 1-888-982-3862 به خوزایی پیامدندی بکن.

Laotian - ທ່າຂູ້ຄ່ານາຂອງທ້າທຽມທ່ານທ້າທຽມທ້າທຽມ 1-888-982-3862 ທ່າຂ່າວ່າຂ່າວ່າ.

Marathi - तीलभाषा (मराठी) सहाय्यासाठी 1-888-982-3862 क्रमांकाच्या कोणत्याही भाषेतील वाचकाकरकरा.

Marshallese - Ñañ bök jipañ ilo Kajin Majol, kallok 1-888-982-3862 ilo ejelok wônän.

Micronesian-Pohnpeian - Ohng palien sawas en souk kawewe ni omw loka Ponape koahl 1-888-982-3862 ni sohte isais.

Mon-Khmer, Cambodian - មកលណារណៈ កន្លែងការេ - 1-888-982-3862 នូវប្រយោជនីភាព

Navajo - T'áá shi shizaad k'ehjí bee shiká a'doowol nínízingo Diné k'ehjí koi' t'áá jík'e hółne' 1-888-982-3862

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

Nilotic-Dinka - Tëñ kucoon ë thok ë Thuorjân coû 1-888-982-3862 kecin ayoc.

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

Panjabi - ਪੰਜਾਬੀ ਕਿਸਾਨ ਕਣਾਕ ਕਿਸਾਨ ਸਤਿ, 1-888-982-3862 `ੜ ਭੁੱਧ ਭਾਸ਼ਾ


Persian - برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 بدون هیچ هزینه ای تماس بگیرید. انگلیسی

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-982-3862.
Para obter assistência lingüística em português ligue para o 1-888-982-3862 gratuitamente.

Pentru asistență lingvistică în româneste telefonați la numărul gratuit 1-888-982-3862

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

Mo fesoasoani tau gagana I le Gagana Samoa vala‘au le 1-888-982-3862 e aunoa ma se totogi.

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

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

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

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

สำหรับความช่วยเหลือทางภาษาเป็น ภาษาไทย โทร 1-888-982-3862 ฟรีไม่มีค่าใช้จ่าย.

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

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

(Dil) çağrısı dil yardımı için. Hiçbir ücret ödemeden 1-888-982-3862.

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

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

Прашер шперэра вич ля Айдиш Рут 1-888-982-3862 Фрі, Піл Апезала.