aetna

Coverage for: Individual + Family | Plan Type: POS



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 1-800-370-4526. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-370-4526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$0. Out-of-Network: Individual \$400 / Family \$1,000.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	No.	You will have to meet the <u>deductible</u> before the <u>plan</u> pays for any services
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In-Network deductible & coinsurance: Individual \$800 / Family \$2,000. In-Network copays: Individual \$7,360 / Family \$14,720. Out-of-Network: Individual \$2,000 / Family \$5,000.	The <u>out–of–pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out–of–pocket limits</u> until the overall family <u>out–of–pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges & health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out–of–pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See <u>www.aetna.com/docfind</u> or call 1-800-370-4526 for a list of in- <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	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.

			ı Will Pay		
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Primary care visit to treat an injury or illness	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply; except no charge for office surgery	30% <u>coinsurance</u>	None	
If you visit a health care provider's	<u>Specialist</u> visit	\$30 copay/visit, deductible doesn't apply; except no charge for office surgery	30% <u>coinsurance</u>	None	
office or clinic	Preventive care /screening /immunization	No charge	Not covered, except 30% coinsurance for immunizations up to age 12 months, mammograms & gynecological exams	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.	
If you have a test	Diagnostic test (x-ray, blood work) Imaging (CT/PET scans, MRIs)	No charge No charge	30% <u>coinsurance</u> 30% <u>coinsurance</u>	None <u>Pre-authorization</u> required for out-of-network care.	
If you need drugs to treat your	Generic drugs Preferred brand drugs Non-preferred brand drugs	Not covered Not covered Not covered	Not covered Not covered Not covered	Not covered.	

Common Medical Event	Services You May Need	What You In-Network Provider (You will pay the least)	u Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
illness or condition More information about prescription drug coverage is available at www.aetna.com/pharmacy-insurance/individual s-families	Specialty drugs	Not covered	Not covered	Not covered.
If you have	Facility fee (e.g., ambulatory surgery center)	No charge	30% coinsurance	None
outpatient surgery	Physician/surgeon fees	No charge	30% coinsurance	None
If you need immediate medical attention	Emergency room care	Deductible doesn't apply: \$150 copay/visit, except \$50 copay/visit with written referral & children up to age 19	Deductible doesn't apply: \$150 copay/visit, except \$50 copay/visit with written referral & children up to age 19	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . No coverage for non-emergency use.
	Emergency medical transportation	10% <u>coinsurance,</u> <u>deductible</u> doesn't apply	30% <u>coinsurance,</u> <u>deductible</u> doesn't apply	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	\$45 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	30% <u>coinsurance</u> after \$500 <u>copay</u> /stay	Pre-authorization required for out-of-network care.
	Physician/surgeon fees	No charge	30% coinsurance	Pre-authorization required for out-of-network care.

		What You Will Pay			
Common Medical	Comisee Vey May Need	In-Network Provider	Out-of-Network Provider	Limitations, Exceptions, & Other Important	
Event	Services You May Need	(You will pay the	(You will pay the	Information	
		least)	most)		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$30 copay/visit, deductible doesn't apply; other outpatient services: no charge	Office & other outpatient services: 30% coinsurance	None	
	Inpatient services	No charge	30% <u>coinsurance</u> after \$500 <u>copay</u> /stay	<u>Pre-authorization</u> required for out-of-network care.	
	Office visits	No charge	30% coinsurance	Cost sharing does not apply for preventive	
	Childbirth/delivery professional services	No charge	30% coinsurance	services. Maternity care may include tests and	
If you are pregnant	Childbirth/delivery facility services	No charge	30% <u>coinsurance</u> after \$500 <u>copay</u> /stay	services described elsewhere in the SBC (i.e., ultrasound). <u>Pre-authorization</u> for out-of-network care may apply.	
	Home health care	No charge	30% coinsurance	<u>Pre-authorization</u> required for out-of-network care.	
	Rehabilitation services	\$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% coinsurance	Out-of- <u>network</u> maximum: 75% of in- <u>network</u> cost up to \$52/visit for Physical Therapy, including outpatient hospital services. <u>Pre-authorization</u> required for out-of-network care.	
If you need help recovering or have other special health needs	Habilitation services	\$30 copay/visit, deductible doesn't apply; except no charge for outpatient hospital facility	30% <u>coinsurance</u>	None	
	Skilled nursing care	No charge	30% <u>coinsurance</u> after \$500 <u>copay</u> /stay	120 days/calendar year in-network & 60 days out-of-network/calendar year. Pre-authorization required for out-of-network care.	
	<u>Durable medical equipment</u>	10% <u>coinsurance,</u> <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.	

Co	ommon Medical Event	Services You May Need	What You In-Network Provider (You will pay the least)	ı Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
		Hospice services	No charge	30% coinsurance after \$500 copay/stay for inpatient; 30% coinsurance for outpatient	Pre-authorization required for out-of-network care.
_	our child needs	Children's eye exam	\$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not covered	1 routine eye exam/calendar year.
aer	ntal or eye care	Children's glasses	Not covered	Not covered	Not covered.
		Children's dental check-up	Not covered	Not covered	Not covered.

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 & Child)
- Glasses (Child)

- Long-term care
- Non-emergency care when traveling outside the U.S.
- Prescription drugs

- Routine foot care
- Weight loss programs

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

- Acupuncture Limited to disease, injury & chronic pain. Out-of-<u>network</u> maximum: 75% of in-<u>network</u> cost up to \$60/visit.
- Bariatric surgery
- Chiropractic care 30 visits/calendar year.
 Out-of-<u>network</u> maximum: 75% of in-<u>network</u> cost up to \$35/visit.
- Hearing aids 1 hearing aid to \$2,500 maximum per ear/60 months.
- Infertility treatment For more information & exceptions, see policy document provided by your employer or call the number on your ID card.
- Private-duty nursing
- Routine eye care (Adult) 1 routine eye exam/calendar year for in-network only.

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 <u>plan</u> at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health <u>plans</u>, 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 <u>www.cciio.cms.gov</u>.
- If your coverage is a church <u>plan</u>, church <u>plans</u> 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 <u>Health Insurance Marketplace</u>. 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 <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your plan documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-800-370-4526. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health <u>plans</u>, 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 <u>www.cciio.cms.gov</u>.
- Additionally, a consumer assistance program can help you file your <u>appeal</u>. 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.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? 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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 <u>plan's</u> overall <u>deductible</u>	\$0
■ Specialist copayment	\$30
■ Hospital (facility) <u>copayment</u>	\$0
Other copayment	\$0

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	\$12,700
In this example, Peg would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$70
The total Peg would pay is	\$70

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

■ The <u>plan's</u> overall <u>deductible</u>	\$0
Specialist copayment	\$30
■ Hospital (facility) <u>copayment</u>	\$0
Other <u>copayment</u>	\$0

This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (including disease education)

Diagnostic tests (blood work)

Prescription drugs

Diabetic supplies (glucose meter)

\$5,600		
\$0		
\$200		
\$0		
What isn't covered		
\$4,300		
\$4,500		

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$0
Specialist copayment	\$30
■ Hospital (facility) copayment	\$0
Other consyment	\$0

This EXAMPLE event includes services like:

<u>Emergency room care</u> (including medical supplies)

Diagnostic test (x-ray)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$2,800	
n this example, Mia would pay:		
Cost Sharing		
<u>Deductibles</u>	\$0	
<u>Copayments</u>	\$300	
<u>Coinsurance</u>	\$90	
What isn't covered		
Limits or exclusions	\$10	
The total Mia would pay is	\$400	

Note: These numbers assume the patient does not participate in the <u>plan's</u> wellness program. If you participate in the <u>plan's</u> wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-370-4526.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-370-4526.

Smartphone or Tablet

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

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, disability, gender identity or sexual orientation.

We provide 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: P.O. Box 24030, Fresno, CA 93779),

1-800-648-7817, TTY: 711,

Fax: 859-425-3379 (CA HMO customers: 860-262-7705), 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 companies, including Aetna Life Insurance Company and its affiliates (Aetna).

TTY: 711

Language Assistance:

To access language services at no cost to you, call 1-800-370-4526.

Albanian - Për shërbime përkthimi falas për ju, telefononi 1-800-370-4526.

Amharic - የቋንቋ አ*า*ል ማሎቶችን ያለክፍያ ለማ ማኘት፣ በ 1-800-370-4526 ይደውሉ።

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء االتصال على الرقم 4526-370-4526 اللغوية دون أي تكلفة، الرجاء التصال على الرقم 4526-370-1-800

Armenian - Անվձար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-800-370-4526 հեռախոսահամարով։

Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.

Bantu-Kirundi - Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-800-370-4526.

370-4526 □

Bisayan-Visayan - Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-800-370-4526.

Burmese - သင့္အေနျဖင့္ အခေၾကးေငြ မေပးရပဲ ဘာသာစကားဝန္ေဆာင္မႈမ်ား ရရွိႏုိင္ရန္ 1-800-370-4526 သို႕ ဖုန္းေခၚဆုိပါ။

Catalan - Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-800-370-4526.

Chamorro - Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-800-370-4526.

Chinese - 如欲使用免費語言服務, 請致電 1-800-370-4526.

Choctaw - Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-800-370-4526.

Cushite - Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-800-370-4526.

Dutch - Voor gratis toegang tot taaldiensten, bell 1-800-370-4526.

French - Afin d'accéder aux services langagiers sans frais, composez le 1-800-370-4526.

French Creole - Pou jwenn sèvis lang gratis, rele 1-800-370-4526.

German - Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-800-370-4526 an.

Greek - Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό

1-800-370-4526.

તમારેકોઇ જાતના ખર્યવિના ભાષાની સેિાઓની પહોોંર માટે, કોલ કરો1-800-370-4526. Gujarati -Hawaiian -No ka wala'au 'ana me ka lawelawe 'ōlelo e kahea aku i kēia helu kelepona 1-800-370-4526. Kāki 'ole 'ia kēia kōkua nei. आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए, 1-800-370-4526 पर कॉल करें। Hindi -Hmong -Xav tau kev pab txhais lus tsis muaj ngi them rau koj, hu 1-800-370-4526. lji nwetaòhèrè na oru gasi asusu n'efu, kpoo 1-800-370-4526 Igbo -Ilocano -Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-800-370-4526. Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-800-370-4526. Indonesian -Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-800-370-4526. Italian -言語サービスを無料でご利用いただくには、1-800-370-4526 までお電話ください。 Japanese -လာတါကမႈနှုံကိုဉ်အတါမူးစားအတါဖုံးတာမြာတဖဉ်လာတအိဉ်ဒီးအပူးလာကဘဉ်ဟုဉ်အီးအဂ်ီးဘဉ်နှဉ် ကိုး 1-800-370-4526 တက္၏ Karen -무료 언어 서비스를 이용하려면 1-800-370-4526 번으로 전화해 주십시오. Korean -Kru-Bassa -M□ dyi wudu-dù kà kò dò bě dyi moú ń nì Pídyi ní, nìí, dá no bà nìà kɛ: 1-800-370-4526 بۆ دەسبېر اگەيشتن به خزمه تگوز ارى زمان بەبئ تېچوون بۆ تۆ، پەيوەندى بكه به ژمارەي 4526-370-800-1 Kurdish -ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-800-370-4526 Laotian -कोणत्याही शल्ुकालशवाय भाषा सेवा प्राप्त करण्यासाठी,, 1-800-370-4526 वर फोन करा. Marathi -Marshallese -Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-800-370-4526. Micronesian-Pohnpeyan -Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-800-370-4526. Mon-Khmer, _____1-800-370-4526 Ч Cambodian -Navajo -T'áá ni nizaad k'ehjí bee níká a'doowoł doo bááh ílínígóó kojj' hólne' 1-800-370-4526. Nepali -Nilotic-Dinka -Të koor yin wεεi de thokic ke cin wëu kor keek tënon yin. Ke col koc ye koc kuony ne nomba 1-800-370-4526.

Norwegian - For tilgang til kostnadsfri språktjenester, ring 1-800-370-4526.

Pennsylvania Dutch - Um Schprooch Services zu griege mitaus Koscht, ruff 1-800-370-4526.

برای دسترسی به خدمات زبان به طور رایگان، با شماره 4526-370-4500 تماس بگیرید . Persian -

Polish - Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-800-370-4526.

Portuguese - Para acessar os serviços de idiomas sem custo para você, ligue para 1-800-370-4526.

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Romanian - Pentru a accesa gratuit serviciile de limbă, apelați 1-800-370-4526.

Russian - Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-800-370-4526.

Samoan - Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-800-370-4526.

Serbo-Croatian - Za besplatne prevodilačke usluge pozovite 1-800-370-4526.

Spanish - Para acceder a los servicios de idiomas sin costo, llame al 1-800-370-4526.

Sudanic-Fulfude - Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-800-370-4526.

Swahili - Kupata huduma za lugha bila malipo kwako, piga 1-800-370-4526.

Syriac - : معبقه ، فبحت خلاته ، مغبنه ، مغبنه

Tagalog - Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-800-370-4526.

Telugu - మీరు భాష సేవలను ఉచితంగా అందుకునందుకు, 1-800-370-4526 కు కాల్ చేయండి.

Thai - หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-800-370-4526.

Tongan - Kapau 'oku ke fiema'u ta'etōtōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-800-370-4526.

Trukese - Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-800-370-4526.

Turkish - Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-800-370-4526 numarayı arayın.

Ukrainian - Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-800-370-4526.

بالقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 4526-370-4520 پر بات کریں۔

Vietnamese - Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-800-370-4526.

Yiddish - 1-800-370-4526 צו צוטריט שּפרַאך בַאדינונגען אין קיין פרייַז צו איר, רופן

Yoruba - Lati wonú awon ise èdè l'ofe fun o, pe 1-800-370-4526.