



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](http://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 <u>deductible</u> ?                             | \$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 <u>deductible</u> ? | 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 limit</u> for this <u>plan</u> ?       | In-Network: Individual \$800 / Family \$2,000. In-Network <u>copays</u> : Individual \$8,480 / Family \$16,960. 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 <u>out-of-pocket limit</u> ?            | <u>Premiums</u> , <u>balance-billing</u> charges & health care this <u>plan</u> 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 <u>network provider</u> ?            | 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- <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</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u> ?          | No.                                                                                                                                                                  | You can see the <u>specialist</u> you choose without a <u>referral</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event                                          | Services You May Need                                   | What You Will Pay                                                                              |                                                                                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                  |
|---------------------------------------------------------------|---------------------------------------------------------|------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                               |                                                         | In-Network Provider<br>(You will pay the least)                                                | Out-of-Network Provider<br>(You will pay the most)                                                                 |                                                                                                                                                                         |
| If you visit a health care <u>provider's</u> office or clinic | 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                                                                                                                                                                    |
|                                                               | <u>Specialist</u> visit                                 | \$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply; except no charge for office surgery | 30% <u>coinsurance</u>                                                                                             | None                                                                                                                                                                    |
|                                                               | <u>Preventive care</u> / <u>screening</u> /immunization | No charge                                                                                      | Not covered, except 30% <u>coinsurance</u> 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                                            | <u>Diagnostic test</u> (x-ray, blood work)              | No charge                                                                                      | 30% <u>coinsurance</u>                                                                                             | None                                                                                                                                                                    |
|                                                               | Imaging (CT/PET scans, MRIs)                            | No charge                                                                                      | 30% <u>coinsurance</u>                                                                                             | <u>Pre-authorization</u> required for out-of-network care.                                                                                                              |
| If you need drugs to treat your                               | Generic drugs                                           | Not covered                                                                                    | Not covered                                                                                                        | Not covered.                                                                                                                                                            |
|                                                               | Preferred brand drugs                                   | Not covered                                                                                    | Not covered                                                                                                        |                                                                                                                                                                         |
|                                                               | Non-preferred brand drugs                               | Not covered                                                                                    | Not covered                                                                                                        |                                                                                                                                                                         |

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

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

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

- Acupuncture - Limited to disease, injury & chronic pain. Out-of-network maximum: 75% of in-network cost up to \$60/visit.
- Bariatric surgery
- Chiropractic care - 30 visits/calendar year. Out-of-network maximum: 75% of in-network 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 plan 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 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](http://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](http://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 on how 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:

- 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 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](http://www.cciio.cms.gov).
- 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.**

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

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

**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  |
| ■ <u>Specialist</u> <u>copayment</u>          | \$30 |
| ■ Hospital (facility) <u>copayment</u>        | \$0  |
| ■ Other <u>copayment</u>                      | \$0  |

**This EXAMPLE event includes services like:**  
Primary care physician office visits (*including disease education*)  
Diagnostic tests (*blood work*)  
Prescription drugs  
Diabetic supplies (*glucose meter*)

|                                        |                |
|----------------------------------------|----------------|
| <b>Total Example Cost</b>              | <b>\$5,600</b> |
| <b>In this example, Joe would pay:</b> |                |
| <u>Cost Sharing</u>                    |                |
| <u>Deductibles</u>                     | \$0            |
| <u>Copayments</u>                      | \$200          |
| <u>Coinsurance</u>                     | \$0            |
| <u>What isn't covered</u>              |                |
| Limits or exclusions                   | \$4,300        |
| <b>The total Joe would pay is</b>      | <b>\$4,500</b> |

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

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

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

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

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: 1-800-370-4526.

### 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](mailto: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

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

Amharic - የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-800-370-4526 ይደውሉ።

Arabic - للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-800-370-4526

Armenian - Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-800-370-4526 հեռախոսահամարով:

Carolinian ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-370-4526.

(Kapasal Falawasch) -

Chamorro - Para un hago' i setbision lengguâhi ni dibâtde para hâgu, âgang 1-800-370-4526.

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

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

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

French Creole (Haitian)- 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.

Gujarati - તમારેકોઇ જાતના ખર્ચવિના ભાષાની સે વિના ઓની પહોંર માટે, કોલ કરો 1-800-370-4526.

Hindi - आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए, 1-800-370-4526 पर कॉल करें।

Hmong - Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-800-370-4526.

Italian - Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-800-370-4526.

Japanese - 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。

Karen - လာတက်ကမ္ဘာ့အတိတ်မဟာအတိတ်ဖုံးတက်မဟာဖုလံတအိတ်ဒီးအပူလံကဘတ်ဟုတ်အိတ်အဂီၢ်ဘတ်န့ၣ် ကိး 1-800-370-4526 တက့ၢ်.

Korean - 무료 언어 서비스를 이용하려면 1-800-370-4526 번으로 전화해 주십시오.

Laotian - ເພື່ອຂໍ້ໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-800-370-4526.

Mon-Khmer,   
 1-800-370-4526 ។

Cambodian -

|                      |                                                                                                |
|----------------------|------------------------------------------------------------------------------------------------|
| Navajo -             | T'áá ni nizaad k'ehjí bee níká a'doowoł doo bąąh ílínígóó koji' hólne' 1-800-370-4526.         |
| Pennsylvania Dutch - | Um Schprooch Services zu griege mitaus Koscht, ruff 1-800-370-4526.                            |
| Persian-Farsi -      | برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-800-370-4526 تماس بگیرید.                  |
| 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.            |
| Punjabi -            | □□□□□□ □□ □□□□□□ □□□□ □□□□□□ □□□□ □□□□□□ □□ □□□□□ □□□ □□, 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.                    |
| Syriac-Assyrian -    | □□□□□□□□ □□□□□□□□□ □□□□□□□□ □□□ □□□□□□ □□□□□□□□ □□□□                                           |
|                      | :□□□□□□□□□ □□□□□□□□□□ 1-800-370-4526.                                                          |
| Tagalog -            | Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-800-370-4526. |
| Thai -               | หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-800-370-4526.            |
| Ukrainian -          | Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-800-370-4526.       |
| Vietnamese -         | Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-800-370-4526.          |