<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>Preferred Care: Individual $100 / Family $200. Does not apply to office visits, prescription drugs, and preventive care in-network.</td>
<td>You must pay all the costs up to the <strong>deductible</strong> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <strong>deductible</strong> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <strong>deductible</strong>.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>Yes. For prescription drug expenses - Individual $100 / Family $200. Does not apply to generic drugs. There are no other specific deductibles.</td>
<td>You must pay all of the costs for these services up to the specific <strong>deductible</strong> amount before this plan begins to pay for these services.</td>
</tr>
<tr>
<td><strong>Is there an out-of-pocket limit on my expenses?</strong></td>
<td>Yes. Preferred Care: Individual $2,500 / Family $5,000.</td>
<td>The <strong>out-of-pocket limit</strong> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums, balance-billed charges, and health care this plan does not cover.</td>
<td>Even though you pay these expenses, they don't count toward the <strong>out-of-pocket limit</strong>.</td>
</tr>
<tr>
<td><strong>Is there an overall annual limit on what the plan pays?</strong></td>
<td>No.</td>
<td>The chart starting on page 2 describes any limits on what the plan will pay for <strong>specific</strong> covered services, such as office visits.</td>
</tr>
<tr>
<td><strong>Does this plan use a network of providers?</strong></td>
<td>Yes. See <a href="http://www.aetna.com">www.aetna.com</a> or call 1-888-982-3862 for a list of Preferred Care providers.</td>
<td>If you use an in-network doctor or other health care <strong>provider</strong>, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <strong>provider</strong> for some services. Plans use the term in-network, <strong>preferred</strong>, or participating for <strong>providers</strong> in their <strong>network</strong>. See the chart starting on page 2 for how this plan pays different kinds of <strong>providers</strong>.</td>
</tr>
<tr>
<td><strong>Do I need a referral to see a specialist?</strong></td>
<td>Yes, for in-network <strong>specialists</strong>.</td>
<td>This plan will pay some or all of the costs to see a <strong>specialist</strong> for covered services but only if you have the plan's permission before you see the <strong>specialist</strong>.</td>
</tr>
<tr>
<td><strong>Are there services this plan doesn't cover?</strong></td>
<td>Yes.</td>
<td>Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <strong>excluded services</strong>.</td>
</tr>
</tbody>
</table>
Summary of Benefits and Coverage: What this Plan Covers & What it Costs

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use Preferred Care **providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Preferred Care Provider</th>
<th>Your Cost If You Use a Non-Preferred Care Provider</th>
<th>Limitations &amp; Exceptions</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>$30 copay/visit</td>
<td>Not covered</td>
<td>Includes Internist, General Physician, Family Practitioner or Pediatrician.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$40 copay/visit</td>
<td>Not covered</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>$15 copay/visit</td>
<td>Not covered</td>
<td>Coverage is limited to 20 visits per calendar year for Chiropractic care.</td>
</tr>
<tr>
<td></td>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>Not covered</td>
<td>Age and frequency schedules may apply.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge for laboratory; $40 copay/visit for x-ray</td>
<td>Not covered</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$150 copay/visit</td>
<td>Not covered</td>
<td>none</td>
</tr>
</tbody>
</table>

**Questions:** Call 1-888-982-3862 or visit us at www.HealthReformPlanSBC.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.HealthReformPlanSBC.com or call 1-888-982-3862 to request a copy.
### Summary of Benefits and Coverage: What this Plan Covers & What it Costs

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<th>Services You May Need</th>
<th>Your Cost If You Use a Preferred Care Provider</th>
<th>Your Cost If You Use a Non-Preferred Care Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>Copay/prescription: $10 (retail), $20 (mail order)</td>
<td>Not covered</td>
<td>Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs &amp; devices obtainable from a pharmacy, oral fertility drugs. No charge for formulary generic FDA-approved women's contraceptives in-network. Review your formulary for prescriptions requiring precertification or step therapy for coverage.</td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at <a href="http://www.aetna.com/pharmacy-insurance/individuals-families">www.aetna.com/pharmacy-insurance/individuals-families</a></td>
<td>Preferred brand drugs</td>
<td>Copay/prescription: $35 (retail), $70 (mail order)</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>Copay/prescription: $60 (retail), $120 (mail order)</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Premier Three Tier Open Formulary</td>
<td>Specialty drugs</td>
<td>Applicable cost as noted above for generic or brand drugs.</td>
<td>Not covered</td>
<td>First prescription must be filled at a participating retail pharmacy or Aetna Specialty Pharmacy Networks. Subsequent fills must be through Aetna Specialty Pharmacy Networks.</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% coinsurance for hospital facility; $250 copay/visit, after deductible for free standing facility</td>
<td>Not covered</td>
<td>————none———</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance for hospital facility; 0% coinsurance for free standing facility</td>
<td>Not covered</td>
<td>————none———</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>$100 copay/visit, after deductible</td>
<td>$100 copay/visit, after deductible</td>
<td>No coverage for non-emergency use.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$100 copay/trip, after deductible</td>
<td>$100 copay/trip, after deductible</td>
<td>No coverage for non-emergency transport.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$50 copay/visit</td>
<td>Not covered</td>
<td>No coverage for non-urgent use.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% coinsurance</td>
<td>Not covered</td>
<td>————none———</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>10% coinsurance</td>
<td>Not covered</td>
<td>————none———</td>
</tr>
</tbody>
</table>

**Questions:** Call 1-888-982-3862 or visit us at www.HealthReformPlanSBC.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.HealthReformPlanSBC.com or call 1-888-982-3862 to request a copy.
### Summary of Benefits and Coverage: What this Plan Covers & What it Costs

#### Coverage for: Individual + Family | Plan Type: EPO

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Preferred Care Provider</th>
<th>Your Cost If You Use a Non-Preferred Care Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you have mental health, behavioral health, or substance abuse needs</strong></td>
<td>Mental/Behavioral health outpatient services</td>
<td>$40 copay/visit</td>
<td>Not covered</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>10% coinsurance</td>
<td>Not covered</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>$40 copay/visit</td>
<td>Not covered</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>10% coinsurance</td>
<td>Not covered</td>
<td>none</td>
</tr>
</tbody>
</table>

| If you are pregnant | Prenatal and postnatal care | No charge | Not covered | none |
| Delivery and all inpatient services | $30 copay for physician maternity services; 10% coinsurance for facility services | Not covered | Includes outpatient postnatal care. |

| **If you need help recovering or have other special health needs** | Home health care | 0% coinsurance | Not covered | none |
| Rehabilitation services | $40 copay/visit | Not covered | none |
| Habilitation services | $40 copay/visit | Not covered | Coverage is limited to treatment of Autism. |
| Skilled nursing care | 10% coinsurance | Not covered | none |
| Durable medical equipment | 0% coinsurance | Not covered | none |
| Hospice service | 10% coinsurance for inpatient; 0% coinsurance for outpatient | Not covered | none |

| **If your child needs dental or eye care** | Eye exam | No charge | Not covered | Coverage is limited to 1 routine eye exam per 24 months. |
| Glasses | Not covered | Not covered | none |
| Dental check-up | Not covered | Not covered | none |
Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover  (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs - Except for required preventive services.

Other Covered Services  (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care - Coverage is limited to 20 visits per calendar year.
- Infertility treatment - Coverage is limited to the diagnosis and treatment of underlying medical condition.
- Routine eye care (Adult) - Coverage is limited to 1 routine eye exam per 24 months.

Your Rights to Continue Coverage:
If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-982-3862. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact us by calling the toll free number on your Medical ID Card. If your group health plan 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 Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". This plan or policy does provide minimum essential coverage.

Questions: Call 1-888-982-3862 or visit us at www.HealthReformPlanSBC.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.HealthReformPlanSBC.com or call 1-888-982-3862 to request a copy.
Does this Coverage Meet Minimum Value Standard?
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.
About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

<table>
<thead>
<tr>
<th>Having a baby (normal delivery)</th>
<th>Managing type 2 diabetes (routine maintenance of a well-controlled condition)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amount owed to providers:</strong> $7,540</td>
<td><strong>Amount owed to providers:</strong> $5,400</td>
</tr>
<tr>
<td><strong>Plan pays:</strong> $6,780</td>
<td><strong>Plan pays:</strong> $4,520</td>
</tr>
<tr>
<td><strong>Patient pays:</strong> $760</td>
<td><strong>Patient pays:</strong> $880</td>
</tr>
</tbody>
</table>

### Sample care costs:

- **Hospital charges (mother)**: $2,700
- **Routine obstetric care**: $2,100
- **Hospital charges (baby)**: $900
- **Anesthesia**: $900
- **Laboratory tests**: $500
- **Prescriptions**: $200
- **Radiology**: $200
- **Vaccines, other preventive**: $40

**Total**: $7,540

### Patient pays:

- **Deductibles**: $100
- **Copays**: $60
- **Coinsurance**: $400
- **Limits or exclusions**: $200

**Total**: $760

### Sample care costs:

- **Prescriptions**: $2,900
- **Medical Equipment and Supplies**: $1,300
- **Office Visits and Procedures**: $700
- **Education**: $300
- **Laboratory tests**: $100
- **Vaccines, other preventive**: $100

**Total**: $5,400

### Patient pays:

- **Deductibles**: $100
- **Copays**: $700
- **Coinsurance**: $0
- **Limits or exclusions**: $80

**Total**: $880

---

**Questions:** Call 1-888-982-3862 or visit us at www.HealthReformPlanSBC.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.HealthReformPlanSBC.com or call 1-888-982-3862 to request a copy.
Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- No. Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.
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 on the basis of race, color, national origin, age, disability, or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aetna:
- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 14462, Lexington, KY 40512, 1-800-648-7817, TTY 711, Fax 859-425-3379, CRCoordinator@aetna.com.

California HMO/HNO Members: Civil Rights Coordinator, PO Box 24030 Fresno CA, 93779, 1-800-648-7817, TTY 711, Fax 860-262-7705, CRCoordinator@aetna.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (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.
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 - እንነትን በአማርኛ ያስቀር 1-888-982-3862 ያስፋ ብወኔ ለማለፋው ያልተፋ ነው.

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

Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-888-982-3862 կարգավոր գնան.

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 nomero 1-888-982-3862 ku busa.

Bengali-Bangala -  বাংলা ভাষায় সাহায্য চান 1-888-982-3862 এর মাধ্যমে কল করুন।

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

Burmese - (Burmese) ငြိမ်ချရန် ဗီဇာ မြန်မာစိုးစွဲ နိုင်ပါသည်။ 1-888-982-3862 ဖြင့် သို့မဟုတ်

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

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

Cherokee - ፳ᏔᏫ ᏃᏣᏫ, ᏢᏫᏫ ᎨᏫᏫᏫ ᏠᏫ (GWW) ᏊᏫᏫᏫᏫ, 1-888-982-3862 ᏠᏫ Enrollment ᏫᏫ.Ꮻ.Ꮻ.Ꮻ.

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

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

Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa 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 appeler 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 - �� �� �� �� �� �� �� �� �� �� �� �� �� �� �� �� 1-888-982-3862 �� �� �� �� �� �� ��.

Hindi - 1-888-982-3862

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

Ibo - Maka enyemaka asusụ na Igbo kpọọ 1-888-982-3862 na akwughị ụgwo ọ buła

Ilocano - Para iti tulong ti pasasaso iti pasasaso 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 - Bé mín ke gbo-kpá-kpá dyé pidyi dé Básóó-wụqụń wéé, dá 1-888-982-3862

Kurdish - 1-888-982-3862

Laotian - 1-888-982-3862

Marathi - 1-888-982-3862

Marshallese - Ñan bōk jipaŋ ilo Kajin Majol, kallok 1-888-982-3862 ilo ejjelok wōnān.

Micronesian - Ohng palien sawas en soum kawewe ni omw lokaia Ponape koahl 1-888-982-3862 ni sohte isais.

Mon-Khmer, Cambodian - 1-888-982-3862

Navajo - T’áá shi shizaad k’ehjí bee shiká a’dowol mínízingo Diné k’ehjí koji’ t’áá jíík’e hólne’ 1-888-982-3862

Nepali - 1-888-982-3862

Niletic-Dinka - Tën kućonj é thok é Thuŋjāŋ col 1-888-982-3862 kecín ayoc.

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


Persian - برای راهنمایی به زبان فارسی باشماره 1-888-982-3862

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-982-3862.

Portuguese - Para obter assistência linguística em português ligue para o 1-888-982-3862 gratuitamente.
Punjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ, 1-888-982-3862 ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Romanian - Pentru asistență lingvistică în română, telefonați la numărul gratuit 1-888-982-3862.
Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-888-982-3862.
Samoan - Mo fesoasoani tau gagana le Gagana Samoa vala’au le 1-888-982-3862 e aunoa ma se totogi.
Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatni broj 1-888-982-3862.
Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-888-982-3862.
Sudanic-Fulfude - Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-888-982-3862. Njodi woo fawaaki on.
Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-888-982-3862 bila malipo.
Syrian - لزجح بكير مالك نشاطات الكلاحية باللغة الإسبانية 1-888-982-3862
Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-982-3862 nang walang bayad.
Telugu - తూగ్గార విభాగంలో నుండి తెలుగు భాషా సహాయాన్ని పొందాలి నంబరు 1-888-982-3862 తేదీలో మండి కోసం.
Thai - ภาษาไทย โทร 1-888-982-3862.
Tongan - Kapau ‘oku fiema’u hā tokoni ‘i he lea faka-Tonga telefoni 1-888-982-3862 o ‘ikai hā totōngi.
Turkese-Chuukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-888-982-3862 nge esapw kamé ngonuk.
Turkish - (Dil) çağırlı dil yardım için. Hiçbir ücret ödemeden 1-888-982-3862.
Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-982-3862.
Urdu - اہمیت کے لئے 1-888-982-3862 سے کانکان را۔
Vietnamese - Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-888-982-3862.
Yiddish - פפר שפראך הילך און אייזיש רופט 1-888-982-3862.
Yoruba - Fún iránlọwọ nípa èdè (Yorùbá) pe 1-888-982-3862 lái san owó kankan rárá.