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

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>UCHP Home Host UCHP Network: $0.</td>
<td>See the Common Medical Events chart below for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>No.</td>
<td>You will have to meet the deductible before the plan pays for any services</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>Home Host UCHP Network: Individual $1,500 / Family $3,000.</td>
<td>The out–of–pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out–of–pocket limits until the overall family out–of–pocket limit has been met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges &amp; health care this plan doesn't cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out–of–pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.aetna.com/dse/custom/uchp">http://www.aetna.com/dse/custom/uchp</a> for a list of Primary Care Providers (PCP) or call 1-855-824-3632 for UCHP Network providers. Your PCP will handle all referrals to a network specialist</td>
<td>This plan uses a provider network limited to the University of Chicago Medical Center providers covered under the UCHP health plan. There is no coverage outside of the UCHP network.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>Yes.</td>
<td>This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.</td>
</tr>
</tbody>
</table>
All *copayment* and *coinsurance* costs shown in this chart are after your *deductible* has been met, if a *deductible* applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$25 <em>copay</em>/visit</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Specialist visit</td>
<td>$45 <em>copay</em>/visit</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>Not covered</td>
<td>You may have to pay for services that aren’t preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No charge</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>Filled at DCAM: $5 <em>copay</em>/30 day prescription $10 <em>copay</em>/90 day prescription</td>
<td>Not covered</td>
<td>Members filling order at a retail pharmacy (i.e. CVS) will receive two prescription fills at the copayment amount. For the third and subsequent fills, the member’s cost will be 50% of the medication cost.</td>
</tr>
</tbody>
</table>

More information about *prescription drug coverage* is available at [www.caremark.com/wps/portal/welcome_page](http://www.caremark.com/wps/portal/welcome_page)
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Preferred brand drugs</td>
<td>Home Host Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Filled at DCAM: $15 copay/30 day prescription $30 copay/90 day prescription</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Filled at Retail Pharmacy: $30 copay/30 day prescription</td>
<td>Members filling order at a retail pharmacy (i.e. CVS) will receive two prescription fills at the copayment amount. For the third and subsequent fills, the member’s cost will be 50% of the medication cost.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Filled by CVS Caremark Mail Order: $60 copay/90 day prescription</td>
<td></td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Non-preferred brand drugs</td>
<td></td>
<td>Members filling order at a retail pharmacy (i.e. CVS) will receive two prescription fills at the copayment amount. For the third and subsequent fills, the member’s cost will be 50% of the medication cost.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Filled at DCAM: $30 copay/30 day prescription $60 copay/90 day prescription</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Filled at Retail Pharmacy: $50 copay/30 day prescription</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Filled by CVS Caremark Mail Order: $100 copay/90 day prescription</td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Home Host Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>---------------------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Specialty drugs</td>
<td>$75 copay/prescription for 30 day order</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$125 copay/visit</td>
<td>$125 copay/visit</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency medical transportation</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Urgent care</td>
<td>$45 copay/visit</td>
<td>$45 copay/visit</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$350 copay/stay</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------</td>
<td>----------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Home Host Network Provider (You will pay the least): $25 copay/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Outpatient services: $25 copay/visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Out-of-Network Provider (You will pay the most): $350 copay/stay</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Inpatient services</td>
<td>$350 copay/stay</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Specialist office visit copay of $45 applies for initial visit only.</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Childbirth/delivery professional services</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Childbirth/delivery facility services</td>
<td>$350 copay/stay</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------</td>
<td>----------------------------</td>
<td>------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Rehabilitation services</td>
<td>Home Host Network Provider (You will pay the least): No charge</td>
<td>Out-of-Network Provider (You will pay the most): Not covered</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Habilitation services</td>
<td>Home Host Network Provider (You will pay the least): No charge</td>
<td>Out-of-Network Provider (You will pay the most): Not covered</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Skilled nursing care</td>
<td>Home Host Network Provider (You will pay the least): No charge</td>
<td>Out-of-Network Provider (You will pay the most): Not covered</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Durable medical equipment</td>
<td>Home Host Network Provider (You will pay the least): No charge</td>
<td>Out-of-Network Provider (You will pay the most): Not covered</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Hospice services</td>
<td>Home Host Network Provider (You will pay the least): No charge</td>
<td>Out-of-Network Provider (You will pay the most): Not covered</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>Home Host Network Provider (You will pay the least): $45/visit for one visit/lifetime; otherwise Not covered</td>
<td>Out-of-Network Provider (You will pay the most): Not covered</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's glasses</td>
<td>Home Host Network Provider (You will pay the least): Not covered</td>
<td>Out-of-Network Provider (You will pay the most): Not covered</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's dental check-up</td>
<td>Home Host Network Provider (You will pay the least): Not covered</td>
<td>Out-of-Network Provider (You will pay the most): Not covered</td>
</tr>
</tbody>
</table>
Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
</tr>
<tr>
<td>Chiropractic care</td>
</tr>
<tr>
<td>Cosmetic surgery</td>
</tr>
<tr>
<td>Dental care (Adult &amp; Child)</td>
</tr>
<tr>
<td>Glasses (Child)</td>
</tr>
</tbody>
</table>

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

| Bariatric surgery | Infertility treatment |

Your Rights to Continue Coverage:
There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For more information on your rights to continue coverage, contact the plan at 1-888-982-3862.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or: [https://www.dol.gov/agencies/ebsa](https://www.dol.gov/agencies/ebsa)
- 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 to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-888-982-3862.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [https://www.dol.gov/agencies/ebsa](https://www.dol.gov/agencies/ebsa)
- 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](http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html).
Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value 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 plan's overall deductible: $0
- Specialist copayment: $45
- Hospital (facility) copayment: $350
- 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)

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$12,800</th>
</tr>
</thead>
</table>

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$395</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td><strong>What isn't covered</strong></td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$0</td>
</tr>
</tbody>
</table>

The total Peg would pay is $395

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

- The plan's overall deductible: $0
- PCP copayment: $25
- Hospital (facility) copayment: $350
- Other copayment RX: $10

This EXAMPLE event includes services like:
- Primary care physician office visits – 3 (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs
- Durable medical equipment (glucose meter)

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$7,400</th>
</tr>
</thead>
</table>

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$115</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td><strong>What isn't covered</strong></td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$0</td>
</tr>
</tbody>
</table>

The total Joe would pay is $115

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

- The plan's overall deductible: $0
- Specialist copayment: $45
- Hospital (facility) copayment: $125
- Other copayment: $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)

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$1,900</th>
</tr>
</thead>
</table>

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$215</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td><strong>What isn't covered</strong></td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$0</td>
</tr>
</tbody>
</table>

The total Mia would pay is $215

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Note: If your plan has a wellness program and you choose to participate, you may be able to reduce your costs.
Assistive Technology
Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-982-3862.

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

Non-Discrimination
Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705),

Email: CRCordinator@aetna.com.

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

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

Language Assistance:

For language assistance in your language call 1-888-982-3862 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-888-982-3862.
Amharic - እንዳሁን ለማ እንዳሁን በ 1-888-982-3862 የተጠቀጫ.
Arabic - للمساعدة في (اللغة العربية)، الراجعون الاند التصال على الرقم المجاني 1-888-982-3862 22.
Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի (1-888-982-3862) առանց գնով.
Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya.
Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-888-982-3862 ku busa
Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-888-982-3862-তে কল করুন।
Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-982-3862 nga walay bayad.
Burmese - ပထမ့်ပြောင်းလဲခြင်း ပြုလုပ်ပါ 1-888-982-3862 ဖြင့် ကြည့်ပါသည်။
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 gåstu.
Cherokee - ᎠᏂᏍᏗ ᎠᏂᏍᏗ ᎠᏂᏍᏗ ᎝ᏗᏣ ᎠᏙᏗ ᎠᏝᏗ (GWW) ᎠᏝᏗᏗ 1-888-982-3862 ᎠᏙᏗ ᎠᏝᏗ ᎠᏝᏗ ᎠᏝᎣ ᎠᏝᏗ ᎠᏝᏗ.
Chinese - 欲取得繁體中文語言協助，請撥打 1-888-982-3862，無需付費。
Choctaw - (Chahta) anumpa ya apela a chi l paya hinla 1-888-982-3862.
Cushite - Gargaarsa afan Oromiffa hiikuu argachuuf lakkokkofsa bilbila 1-888-982-3862 irratti bilisaan bilbila.
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 asitsans nan lang Kreyòl Ayisyen, rele nimewo 1-888-982-3862 gratis.
German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-982-3862 an.
Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-982-3862 χωρίς χρέωση.
Gujarati - ગુજરાતીમાં લાંબા સલાહ માટે કોઈપણ અર્થ બાગ 1-888-982-3862 પર કોલ કરો.

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

Hmong - Maka enyemaka asusû na lgbo kpoọ 1-888-982-3862 na akwughì ugwo o bula

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

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

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

Karen - Bèm ké gbo-kpá-kpá dyé pidyi dé Basoö-wuqun wéé, dy 1-888-982-3862

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

Kru-Bassa - Ñan bôk jipañ ilo Kajin Majol, kallok 1-888-982-3862 ilo ejjelok wônän.

Laotian - Tielbasha (marathi) sahayyasaathi 1-888-982-3862 kramaakwarkoconatvahiayshiyawankolakara.

Marathi - तीलभाषा (मराठी) सहाय्यासाठी 1-888-982-3862 क्रमांकावरकोणत्याहीखर्ााशिवायकॉलकरा.

Marshallese - Ohng palien sawas en sou n kawewe ni omw lokaia Ponape koahl 1-888-982-3862 ni sohte isais.

Micronesian - Krmaakwarkoconatvahiayshiyawankolakara.

Mon-Khmer, Cambodian - T'áá shi shaad k'ehjí bee shiká a'doowol nínìzingo Diné k'ehjí koi' t'áá jík'e hólne' 1-888-982-3862

Navajo - T'áá shi shaad k'ehjí bee shiká a'doowol nínìzingo Diné k'ehjí koi' t'áá jík'e hólne' 1-888-982-3862

Nepali - (लेपाली) मा नि:शुल्क भाषा सहायता पाउनका लागि 1-888-982-3862 मा फोन गर्नुहोस्।

Nilotic-Dinka - Tên kùonny ê thok ê Thuorrejän cöl 1-888-982-3862 kecin ayôc.

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

Panjabi - ਪੰਜਾਬੀ ਵ ਦੰਦੀ ਧਰਤੀ ਮਹਾਂਦੀ ਲੋਕੀ, 1-888-982-3862 ਦੁਖ ਵਰਤ ਵਲੇ।


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

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

Pentru asistență lingvistică în română, atingeți numărul gratuit 1-888-982-3862.

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

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

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

Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-888-982-3862. Njodi woo fa waaki on.

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

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

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

สำหรับควำมช่วยเหลือทำงด้ำนภำษำเป็น ภำษำไทย โทร 1-888-982-3862 ฟรีไม่มีค่ำใช้จ่ำย

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

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

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

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

Dé được hỗ trợ ngôn ngữ bằng (ngôn ngữ) hay goi miễn phí đến số’1-888-982-3862.

Fún ìrànlọ́wọ́ nípa èdè (Yorùbá) pe 1-888-982-3862 lái san owó kankan rára.