<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>$0. Out-of-Network: Individual $500 / Family $1,500.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. Emergency care &amp; inpatient hospital services are covered before you meet your deductible.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a></td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>In-Network: Individual $3,000 / Family $9,000. Out-of-Network: Individual $3,000 / Family $9,000.</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><strong>What is not included in the out-of-pocket limit?</strong></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>Important Questions</td>
<td>Answers</td>
<td>Why This Matters:</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-888-982-3862 for a list of in-network providers.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay In-Network Provider (You will pay the least)</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><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>$25 copay/visit, deductible doesn't apply</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$50 copay/visit deductible doesn't apply</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>$25 copay/visit, deductible doesn't apply</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$25 copay/visit, deductible doesn't apply</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your</strong></td>
<td>Generic drugs</td>
<td>Not covered</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>Not covered</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>Not covered</td>
<td>Not covered</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>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
<td>--------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>illness or condition</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$50 copay/visit, deductible doesn't apply</td>
<td>0% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>0% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$150 copay/visit, deductible doesn't apply</td>
<td>$150 copay/visit, deductible doesn't apply</td>
<td>Out-of-network emergency use paid the same as in-network. No coverage for non-emergency use.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No charge</td>
<td>No charge</td>
<td>Out-of-network emergency use paid the same as in-network.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$50 copay/visit, deductible doesn't apply</td>
<td>20% coinsurance</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>$300 copay/stay, deductible doesn't apply</td>
<td>$300 copay/stay, deductible doesn't apply</td>
<td>Max copay/calendar year: $900.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay In-Network Provider (You will pay the least)</td>
<td>What You Will Pay Out-of-Network Provider (You will pay the most)</td>
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</tr>
<tr>
<td>---------------------</td>
<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>Office: $25 copay/visit, deductible doesn't apply; other outpatient services: no charge</td>
<td>Office &amp; other outpatient services: 20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>$300 copay/stay, deductible doesn't apply</td>
<td>$300 copay/stay, deductible doesn't apply</td>
<td>Max copay/calendar year: $900.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>20% coinsurance</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). Max copay/calendar year: $900.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge</td>
<td>20% coinsurance</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). Max copay/calendar year: $900.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$300 copay/stay, deductible doesn't apply</td>
<td>$300 copay/stay, deductible doesn't apply</td>
<td>Max copay/calendar year: $900.</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>No charge for first 200 visits; 20% coinsurance thereafter</td>
<td>240 visits/calendar year.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$25 copay/visit, deductible doesn't apply</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>No charge</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>No charge</td>
<td>20% coinsurance</td>
<td>90 days/calendar year.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>No charge</td>
<td>20% coinsurance</td>
<td>Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay In-Network Provider (You will pay the least)</td>
<td>What You Will Pay Out-of-Network Provider (You will pay the most)</td>
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<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td>Hospice services</td>
<td>No charge</td>
<td>No charge for inpatient; 0% coinsurance for outpatient</td>
<td></td>
<td>210 days/lifetime for inpatient.</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children's eye exam</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Children's glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Children's dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered.</td>
</tr>
</tbody>
</table>

Excluded Services & Other Covered Services:

**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)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Prescription drugs
- Routine eye care (Adult & Child)
- Routine foot care
- Weight loss programs - Except for required preventive services.

**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.
- Bariatric surgery
- Chiropractic care
- Infertility treatment - For more information & exceptions, see policy document provided by your employer or call the number on your ID card.
- Private-duty nursing

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 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.

• 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 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 1-888-982-3862. 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.

• 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 plan's overall deductible $0
- Specialist copayment $50
- Hospital (facility) copayment $300
- Other copayment $0

This EXAMPLE event includes services like:
- Specialist office visits (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (ultrasounds and blood work)
- Specialist visit (anesthesia)

Total Example Cost $12,700

In this example, Peg would pay:

<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>$500</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td>What isn't covered</td>
<td>$70</td>
</tr>
</tbody>
</table>

The total Peg would pay is $570

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

- The plan’s overall deductible $0
- Specialist copayment $50
- Hospital (facility) copayment $300
- Other copayment $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)

Total Example Cost $5,600

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>$300</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td>What isn't covered</td>
<td>$4,300</td>
</tr>
</tbody>
</table>

The total Joe would pay is $4,600

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

- The plan’s overall deductible $0
- Specialist copayment $50
- Hospital (facility) copayment $300
- 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)

Total Example Cost $2,800

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>$300</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td>What isn't covered</td>
<td>$10</td>
</tr>
</tbody>
</table>

The total Mia would pay is $310
**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 unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, disability, gender identity or sexual orientation.

We provide free aids/services to people with disabilities and to people who need language assistance.

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

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

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

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at [https://ocrportal.hhs.gov/ocr/portal/lobby.jsf](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).
Language Assistance:

To access language services at no cost to you, call 1-888-982-3862.

Albanian - Për shërbime përkthimi falas për ju, telefononi 1-888-982-3862.

Amharic - ያልማርኛ እንጂወጥ እንጂወጥ ያለመጠን ለያዝ ከ1-888-982-3862 ይቀemarks.

Arabic - للحصول على الخدمات اللغوية دون أي تكلفة، الوجهة التصل على الرقم 1-888-982-3862.

Armenian - Սահարօրինակ ծառայությունների համար համար 1-888-982-3862 հեռախոսահամարով:

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

Bantu-Kirundi - Kugira uronke serivisi z’indimi atakiguzi, hamagara 1-888-982-3862.

Bengali-Bangala - আপনার বিনামূল্যে ভাষা পরিকল্পনা পেয়ে হয় এই নম্বর পেরিয়ে আন দেন: 1-888-982-3862।

Bisayan-Visayan - Ngadto maakses ang mga serbisyo sa pinulongang alang libre, tawagan sa 1-888-982-3862.

Burmese - မိမိ၏ ဗားလက်ရှိ ပြောဆိုနေသော ဘာသာစကားများ ရရှိနိုင်ရန် 1-888-982-3862 သိုင်းဆိုမှုကို ဖြည်းပါ။

Catalan - Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-888-982-3862.

Chamorro - Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-888-982-3862.

Cherokee - ᭋ hợᏩᎢᏗ ᏚᏬᏂᏍᎳᏗ ᎤᏳᏗᏛᏁᏗ Ꮭ ᎪᎱᏍᏗ ᏗᏣᏎᏨᏗᏛᏗ, ᏫᎨᎦᏏᎳᏛᏏ 1-888-982-3862.

Chinese - 如欲使用免费語言服務，請致電 1-888-982-3862.

Choctaw - Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-888-982-3862.

Cushite - Tajaajiloota afaanii garuu bilisaa ati argaachuuf,bibili 1-888-982-3862.

Dutch - Voor gratis toegang tot taaldiensten, bell 1-888-982-3862.

French - Afin d’accéder aux services langagiers sans frais, composez le 1-888-982-3862.

French Creole - Pou jwenn sèvis lang gratis, rele 1-888-982-3862.

German - Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-888-982-3862 an.

Greek - Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-888-982-3862.

Gujarati - તમારે જાણી અર્થિત વિષયની સહિત્યશાળી સેટિફિકેટ પણ હોય છે, ડૉક કિરે 1-888-982-3862.
No ka walaʻau ʻana me ka lawelawe ʻōlelo e kahea aku i kēia helu kelepona 1-888-982-3862. Kāki ʻole ʻia kēia kōkua nei.

Hindi - आपके लिए बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, 1-888-982-3862 पर कॉल करें।

Hmong - Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-888-982-3862.

Igbo - Iji nwetaòhèrè na ọrụ gasị asusụ n'efu, kpọọ 1-888-982-3862.

Ilocano - Tapno maaksesyo dagiti serbisio maipapan iti pagasaso nga awan ti bayadanyo, tawagan ti 1-888-982-3862.

Indonesian - Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-888-982-3862.

Italian - Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-888-982-3862.

Japanese - 言語サービスを無料でご利用いただくには、1-888-982-3862までお電話ください。

Karen - သိမ်းဆောင်ရွက်ရှိသောစာရင်းများတွင်စာမျက်နှာများကို 1-888-982-3862 သိမ်းဆောင်ရွက်ပါ။

Korean - 무료 언어 서비스를 이용하려면 1-888-982-3862 번으로 전화해 주십시오.

Kru-Bassa - M̱dyi wuɖu-dù kà kò bë dyì muó ni Pídyí ní, níi, dá nòbà nià ke: 1-888-982-3862

Kurdish - بۆ دەستیارگەیەوەیە بە خۆمە تێژۆرێی زەمان بەم تێژۆرێی بۆ تو تەپەمەندی بەکە بە زەمار 1-888-982-3862

Laotian - ດີພາສາຄົົນຄວາມສຸພາ.tk ຜີພາສາຄົົນຄວາມສຸພາ. 1-888-982-3862

Marathi - कोणत्याही शल्काकाळशवाय भाषा सेवा प्राप्त करण्यासाठी, 1-888-982-3862 वर फोन करा.

Marshallese - Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-888-982-3862.

Micronesian - Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlh 1-888-982-3862.

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

Navajo - T’áá ni nizaad k’ehjí bee niká a’doowoł doo báágh ilínígóo kojjí’ hólne’1-888-982-3862.

Nepali - निशुल्क भाषा सेवा प्राप्त गर्न 1-888-982-3862 मा टेलिफोन गन्नुहोस्।

Nilotic-Dinka - Tē kɔɔr yin wëëc de thökic ke cin wëc kor keek têndë yin. Ke cəl kɔɔ kie kɔɔ kuy nęy ne nɔmba 1-888-982-3862.

Norwegian - For tilgang til kostnadsfri språktjenester, ring 1-888-982-3862.

Pennsylvania Dutch - Um Schprooch Services zu griege mitaus Koscht, ruff 1-888-982-3862.

Persian - تاماس یگریذ 1-888-982-3862 برای دسترسی به خدمات زبان به طور رایگان، با شماره

Polish - Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwoń 1-888-982-3862.
Para acessar os serviços de idiomas sem custo para você, ligue para 1-888-982-3862.

Para tuhade lathi chilah chimbe bhim dunham ko matha nekevwa, chii dwe dwe bunde lathi, 1-888-982-3862. ‘U dwe dwe bunde.

Pentru a accesa gratuit serviciile de limbă, apelați 1-888-982-3862.

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-888-982-3862.

Mo le mauina o auaunaga tau gagana e aunoo ma se totogi, vala’au le 1-888-982-3862.

Za besplatne prevodilačke usluge pozovite 1-888-982-3862.

Para acceder a los servicios de idiomas sin costo, llame al 1-888-982-3862.

Heeba a nasta jangirde djej wolde wola chede bo apelou lamba 1-888-982-3862.

Kupata huduma za lugha bila malipo kwako, piga 1-888-982-3862.

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-888-982-3862.

Mo te kui a nangana ko awo na 1-888-982-3862 na ko te nangana ko awo na.

Para acceder a los servicios de idiomas sin costo, llame al 1-888-982-3862.

Mo le mauina o auaunaga tau gagana e aunoo ma se totogi, vala’au le 1-888-982-3862.

Bantu ede avia awo ni eke si, pe 1-888-982-3862.

Kapau ‘oku ke fiema’u ta’etöngi’a e ngaahi sëvesi kotoa pë he ngaahi lea kotoa, telefoni ki he 1-888-982-3862.

Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-888-982-3862.

Para acceso gratuit serviciile de limbă, apelați 1-888-982-3862.

Pentru a accesa gratuit serviciile de limbă, apelați 1-888-982-3862.

Para acceder a los servicios de idiomas sin costo, llame al 1-888-982-3862.

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Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-888-982-3862 numarayı arayın.

Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-888-982-3862.

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tôi số 1-888-982-3862.

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