Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services ♥aetna[™]

Coverage for: Individual + Family Plan Type: POS



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.HealthReformPlanSBC.com or by calling 1-866-449-6495. 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 1-866-449-6495 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	In- <u>Network</u> : EE Only \$1,500; EE+ Family \$3,000. Out-of-Network: EE Only \$4,500; EE+ Family \$9,000.	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 policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	Yes. In- <u>network preventive care</u> is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <u>https://www.healthcare.gov/coverage/preventive-care-benefits/</u>
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet deductibles for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In- <u>Network</u> : EE Only \$3,650; EE+ Family \$7,300. Out-of-Network: EE Only \$10,200; EE+ Family \$20,400.	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> , the overall family <u>out–of–pocket limit</u> must be met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover & penalties for failure to obtain <u>pre-authorization</u> for services.	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 www.aetna.com/docfind or call 1-866- 449-6495 for a list of in- <u>network providers</u> .	This <u>plan</u> uses a <u>provider</u> <u>network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's</u> <u>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 **<u>copayment</u>** and **<u>coinsurance</u>** costs shown in this chart are after your **<u>deductible</u>** has been met, if a **<u>deductible</u>** applies.

	What You Will Pay			
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	None
If you visit a health	<u>Specialist</u> visit	20% coinsurance	40% coinsurance	None
care <u>provider</u> 's office or clinic	Preventive care /screening /immunization	No charge	20% coinsurance	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 first	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
If you have a test	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None
If you need drugs	Generic drugs	20% coinsurance	20% coinsurance	Mail Order: 20% coinsurance
to treat your	Preferred brand drugs	20% coinsurance	20% coinsurance	Mail Order: 20% coinsurance
illness or	Non-preferred brand drugs	20% coinsurance	20% coinsurance	Mail Order: 20% coinsurance
condition More information about <u>prescription</u> <u>drug coverage</u> is available at <u>www.caremark.com</u>	<u>Specialty drugs</u>	Covered at Preferred or Non- Preferred brand drug coinsurance as applicable	Not covered	None
If you have	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% <u>coinsurance</u>	None
outpatient surgery	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need	Emergency room care	20% coinsurance	20% <u>coinsurance</u>	No coverage for non-emergency use.
immediate medical	Emergency medical transportation	20% coinsurance	20% coinsurance	Non-emergency transport: not covered.
attention	Urgent care	20% coinsurance	40% <u>coinsurance</u>	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% <u>coinsurance</u>	Penalty of 50% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Physician/surgeon fees	20% coinsurance	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or	Outpatient services	Office & other outpatient services: 20% <u>coinsurance</u>	Office & other outpatient services: 40% <u>coinsurance</u>	None

	What You Will Pay			
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
substance abuse services	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Penalty of 50% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Office visits	No charge	40% coinsurance	Cost sharing does not apply for preventive
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	services. Maternity care may include tests and
If you are pregnant	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% coinsurance	services described elsewhere in the SBC (i.e. ultrasound.) Penalty of 50% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
	Home health care	0% <u>coinsurance</u>	0% <u>coinsurance</u>	40 visits/calendar year combined with private- duty nursing. Penalty of 50% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of- network care.
	Rehabilitation services	20% coinsurance	40% coinsurance	None
If you need help	Habilitation services	20% coinsurance	40% coinsurance	None
recovering or have other special health needs	Skilled nursing care	20% coinsurance	40% coinsurance	60 days/calendar year. Penalty of 50% of <u>allowed</u> <u>amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Durable medical equipment	20% coinsurance	40% coinsurance	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Penalty of 50% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.
If your shild needs	Children's eye exam	Not covered	Not covered	Not covered.
If your child needs dental or eye care	Children's glasses	Not covered	Not covered	Not covered.
dental of eye cale	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. 	 Routine eye care (Adult & Child) Routine foot care Weight loss programs - Except for required preventive services.
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Other Covered Services (Limitations may app	ly to these services. This isn't a complete list. Plea	ise see your <u>plan</u> document.)

with home health care.

Your Rights to Continue Coverage:

Quality contracted facility only, in-network only.

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 1-866-449-6495.
- 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 : <u>https://www.dol.gov/agencies/ebsa</u>
- 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 <u>plan</u>, church <u>plans</u> are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance <u>Marketplace</u>. For more information about the <u>Marketplace</u>, visit <u>www.HealthCare.gov</u> or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-866-449-6495.
- 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
- 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 <u>appeal</u>. Contact information is at: <u>http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html</u>.

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 <u>plan's</u> overall <u>deductible</u>	\$1,500
Specialist coinsurance	20%
Hospital (facility) <u>coinsurance</u>	20%
Other <u>coinsurance</u>	20%

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:		
Cost Sharing		
Deductibles	\$1,500	
Copayments	\$0	
Coinsurance	\$2,200	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$3,760	

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>	\$1,500
Specialist coinsurance	20%
Hospital (facility) <u>coinsurance</u>	20%
Other <u>coinsurance</u>	20%

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

Total Example Cost	\$5,600	
In this example, Joe would pay:		
Cost Sharing		
Deductibles	\$1,500	
Copayments	\$0	
Coinsurance	\$800	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$2,320	

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

The plan's overall deductible	\$1,500
Specialist coinsurance	20%
Hospital (facility) <u>coinsurance</u>	20%
Other coinsurance	20%

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:	
Cost Sharing	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,800

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: 1-866-449-6495.

> The plan would be responsible for the other costs of these EXAMPLE covered services. 495050-799381-301006

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-866-449-6495.

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: 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 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 1-866-449-6495 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-866-449-6495.
Amharic -	ለቋንቋ እንዛ በ አማርኛ በ 1-866-449-6495 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 6495-449-1866
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-866-449-6495 առանց գնով։
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-866-449-6495 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-866-449-6495 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামুল্যে 1-866-449-6495-তে কল করুন।
Bisayan-Visayan-	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-866-449-6495 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် ျ-866-449-6495 ကို ခေါ် ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-866-449-6495.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-866-449-6495 sin gåstu.
Cherokee -	Օ ℴ⅁℣ Მ ℁℗ℎ.℈ℴ⅁ <i>⅄</i> ℳℎℴ⅁℁ℙℴ⅁℣ Მ ℄ ፐ (GWУ) ℗ ᲮѠ℺℩℁ 1-866-449-6495 ℺℮ℸ Ը ⅄ℾℴ⅁ℳ Ⅎℇ <u></u> Ωℙℳ ℎℙℝ ℗ .
Chinese -	欲取得繁體中文語言協助,請撥打1-866-449-6495,無需付費。
Choctaw -	(Chahta) anumpa y <u>a</u> apela a chi I p <u>a</u> ya hinla 1-866-449-6495.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-866-449-6495 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-866-449-6495.
French -	Pour une assistance linguistique en français appeler le 1-866-449-6495 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-866-449-6495 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-866-449-6495 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-866-449-6495 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહ્યય માટે કોઈ પણ ખર્ચ વગર 1-866-449-6495 પર કૉલ કરો.

Hawaiian -	No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-866-449-6495. Kāki 'ole 'ia kēia kōkua nei.
Hindi -	हनि्दी में भाषा सहायता के लएि, 1-866-449-6495 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-866-449-6495.
bo -	Maka enyemaka asụsụ na Igbo kpọọ 1-866-449-6495 na akwụghị ụgwọ ọ bụla
locano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-866-449-6495 nga awan ti bayadanyo.
talian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-866-449-6495.
Japanese -	日本語で援助をご希望の方は、1-866-449-6495 まで無料でお電話ください。
Karen -	လ၊ တၢ်မးစၢးတၢ်ကတိးကိုခ်အင်္ဂါ ကိုခ် ကိႏ 1-866-449-6495 လ၊ တအိခ်ဒီးတၢ်လ၊ ၁်ဘူခ်လ၊ ၁်စူးဘခ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-866-449-6495 번으로 전화해 주십시오.
Kru-Bassa -	Ɓε´m`ké gbo-kpá-kpá dyé pidyi dé Ɓašɔɔ́-̀wùduùň wɛ̃ɛ, dá 1-866-449-6495
Kurdish -	بر اي ر اهنمايي به زبان فارسي با شمار ه 6495-449-866 به خوّر ايي پهيومندي بکهن.
_aotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ1-866-449-6495 ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi -	तीलभाषा (मराठी) सहाय्यासाठी 1-866-449-6495 क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-866-449-6495 ilo ejjelok wōnān.
/licronesian- Pohnpeyan - Mon-Khmer, Cambodian -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-866-449-6495 ni sohte isais. សម្ភាប់ជំនួយភាសាជា ភាសាខុមរៃ សូមទូរស័ពទទៅកាន់លខេ 1-866-449-6495 ដោយឥតគិតថុល។ៃ
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-866-449-6495
Nepali -	(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-866-449-6495 मा फोन गर्नुहोस् ।
Nilotic-Dinka-	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-866-449-6495 kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-866-449-6495 kostnadsfritt.
[⊃] anjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-866-449-6495 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
^D ennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-866-449-6495 aa. Es Aaruf koschtet nix.
^D ersian - Polish -	بر ای ر اهنمایی به زبان فارسی با شمار ه 6495-449-1-866 بدون هیچ هزینه ای تماس بگیرید. انگلیسی Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-866-449-6495.

Portuguese -	Para obter assistência linguística em português ligue para o 1-866-449-6495 gratuitamente.
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- Romanian Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-866-449-6495
- Russian Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-866-449-6495.
- Samoan Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-866-449-6495 e aunoa ma se totogi.
- Serbo-Croatian Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-866-449-6495.
- Spanish Para obtener asistencia lingüística en español, llame sin cargo al 1-866-449-6495.
- Sudanic-Fulfude Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-866-449-6495. Njodi woo fawaaki on.
- Swahili Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-866-449-6495 bila malipo.
- Tagalog -Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-866-449-6495 nang walang bayad.
- Telugu భాషతో సాయం కొరకు ఎలాంటి ఖర్సు లేకుండా 1-866-449-6495 కు కాల్ చేయండి. (తెలుగు)
- Thai สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-866-449-6495 ฟรีไม่มีค่าใช้จ่าย
- Tongan Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-866-449-6495 'o 'ikai hā ōtōngi.
- Trukese Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-866-449-6495 nge esapw kamé ngonuk.
- Turkish (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-866-449-6495.
- Ukrainian Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-866-449-6495.
- Vietnamese Đê'được hối trở ngôn ngữ bằng (ngôn ngữ), hay gọi miến phi đến số 1-866-449-6495.
- Yiddish 1-866-449-6495 פאר שפראך הילף אין אידיש רופט 1-866-449-6495
- Yoruba Fún ìrànlowo nípa èdè (Yorùbá) pe 1-866-449-6495 lái san owó kankan rárá.