



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, <https://www.aetnastudenthealth.com/> or by calling 1-877-850-6038. 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 1-877-850-6038 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall <u>deductible</u> ? | For each <u>Plan Year</u> , In- <u>Network</u> and Out-of-Network (combined): Individual \$250 | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . |
| Are there services covered before you meet your <u>deductible</u> ? | Yes. <u>Prescription drugs</u> ; plus in- <u>network</u> <u>preventive care</u> are 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other <u>deductibles</u> for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ? | In- <u>Network</u> and Out-of-Network (combined): Individual \$6,825. | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. |
| What is not included in the <u>out-of-pocket limit</u> ? | <u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover & 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 1-877-480-4161 for a list of in- <u>network</u> providers. | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u> ? | No. | You can see the <u>specialist</u> you choose without a <u>referral</u> . |



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

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---|--|---|--|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | None |
| | <u>Specialist</u> visit | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | None |
| | <u>Preventive care</u> / <u>screening</u> /immunization | No charge | 30% <u>coinsurance</u> | You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | None |
| | Imaging (CT/PET scans, MRIs) | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | None |
| If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at https://www.aetnastudenthealth.com/en/school/686194/members/prescriptions.html | Generic drugs | <u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$10 | 30% <u>coinsurance</u> after <u>copay</u> /prescription, <u>deductible</u> doesn't apply: \$10 | Covers 30-day supply (retail). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in- <u>network</u> . |
| | Preferred brand drugs | <u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$30 | 30% <u>coinsurance</u> after <u>copay</u> /prescription, <u>deductible</u> doesn't apply: \$30 | |
| | Non-preferred brand drugs | <u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$50 | 30% <u>coinsurance</u> after <u>copay</u> /prescription, <u>deductible</u> doesn't apply: \$50 | |
| | <u>Specialty drugs</u> | <u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$100 | 30% <u>coinsurance</u> after <u>copay</u> /prescription, <u>deductible</u> doesn't apply: \$100 | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | None |
| | Physician/surgeon fees | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | None |
| If you need immediate medical attention | <u>Emergency room care</u> | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | No coverage for non-emergency use. |
| | <u>Emergency medical transportation</u> | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | None |
| | <u>Urgent care</u> | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | No coverage for non-urgent use. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|--|--|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | Penalty of \$500 for failure to obtain <u>pre-authorization</u> for care. |
| | Physician/surgeon fees | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | None |
| | Inpatient services | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | Penalty of \$500 for failure to obtain <u>pre-authorization</u> for care. |
| If you are pregnant | Office visits | No charge | 30% <u>coinsurance</u> | <u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply. |
| | Childbirth/delivery professional services | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | |
| | Childbirth/delivery facility services | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | Penalty of \$500 for failure to obtain <u>pre-authorization</u> for care. |
| | <u>Rehabilitation services</u> | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | Includes Physical, Occupational & Speech Therapy. |
| | <u>Habilitation services</u> | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | |
| | <u>Skilled nursing care</u> | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | Penalty of \$500 for failure to obtain <u>pre-authorization</u> for care. |
| | <u>Durable medical equipment</u> | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse. |
| | <u>Hospice services</u> | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | Penalty of \$500 for failure to obtain <u>pre-authorization</u> for care. |
| If your child needs dental or eye care | Children's eye exam | No charge | 30% <u>coinsurance</u> | 1 routine eye exam/ <u>plan</u> year. Covered through the end of the month in which the covered person turns 19. |
| | Children's glasses | No charge | 30% <u>coinsurance</u> | 1 pair of glasses or lenses/ <u>plan</u> year. Covered through the end of the month in which the covered person turns 19. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|----------------------|----------------------------|---|--|--|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Children's dental check-up | No charge | 30% <u>coinsurance</u> | Covered through the end of the month in which the covered person turns 19. |

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.)

- | | | |
|---------------------|-----------------------|---|
| • Bariatric surgery | • Dental care (Adult) | • Routine foot care |
| • Cosmetic surgery | • Long-term 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 | • Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition. | • Non-emergency care when traveling outside the U.S. |
| • Chiropractic care | | • Routine eye care (Adult) - 1 routine eye exam/ <u>plan</u> year. |

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: Ohio Department of Insurance, (614)-644-2658, TDD: (614) 644-3745, (800) 686-1526, <https://insurance.ohio.gov>. For more information on your rights to continue coverage, contact the plan at 1-877-850-6038. 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 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 1-877-850-6038 or Ohio Department of Insurance, (614)-644-2658, TDD: (614) 644-3745, (800) 686-1526, <https://insurance.ohio.gov>.

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-850-6038.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-850-6038.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-850-6038.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiiijigo holne' 1-877-850-6038.

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> | \$250 |
| ■ <u>Specialist</u> 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 | \$12,800 |
| In this example, Peg would pay: | |
| <u>Cost Sharing</u> | |
| <u>Deductibles</u> | \$250 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$2,500 |
| <u>What isn't covered</u> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$2,810 |

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> | \$250 |
| ■ <u>Specialist</u> 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 | \$7,400 |
| In this example, Joe would pay: | |
| <u>Cost Sharing</u> | |
| <u>Deductibles</u> | \$250 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$1,400 |
| <u>What isn't covered</u> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$1,670 |

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

| | |
|---|-------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$250 |
| ■ <u>Specialist</u> coinsurance | 20% |
| ■ Hospital (facility) <u>coinsurance</u> | 20% |
| ■ Other <u>coinsurance</u> | 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 | \$1,900 |
| In this example, Mia would pay: | |
| <u>Cost Sharing</u> | |
| <u>Deductibles</u> | \$250 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$330 |
| <u>What isn't covered</u> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$580 |

The plan would be responsible for the other costs of these EXAMPLE covered services.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-877-850-6038.

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.

Language Assistance:

| | |
|--------------------|--|
| Albanian - | Për asistencë në gjuhën shqipe telefononi falas në 1-877-850-6038. |
| Amharic - | ለቋንቋ እገዛ በ አማርኛ በ 1-877-850-6038 በነጻ ይደውሉ |
| Arabic - | 1-877-850-6038 للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني |
| Armenian - | Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-877-850-6038 առանց գնով: |
| Bahasa Indonesia - | Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-877-850-6038 tanpa dikenakan biaya. |
| Bantu-Kirundi - | Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-877-850-6038 ku busa |
| Bengali-Bangala - | বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-877-850-6038-তে কল করুন। |
| Bisayan-Visayan - | Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-877-850-6038 nga walay bayad. |
| Burmese - | ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-877-850-6038 ကို ခေါ်ဆိုပါ။ |
| Catalan - | Per rebre assistència en (català), truqui al número gratuït 1-877-850-6038. |
| Chamorro - | Para ayuda gi fino' (Chamoru), ágang 1-877-850-6038 sin gástu. |
| Cherokee - | ᎠᎩᏚᏰᎦ ᏚᏐᎩᎦᏚᏰᎦ ᎠᎩᏚᏰᎦ ᎠᎩᏚᏰᎦ ᎠᎩᏚᏰᎦ (GWY) ᎠᎩᏚᏰᎦ 1-877-850-6038 ᎠᎩᏚᏰᎦ ᎠᎩᏚᏰᎦ ᎠᎩᏚᏰᎦ. |
| Chinese - | 欲取得繁體中文語言協助，請撥打 1-877-850-6038，無需付費。 |
| Choctaw - | (Chahta) anumpa ya apela a chi l paya hinla 1-877-850-6038. |
| Cushite - | Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-877-850-6038 irratti bilisaan bilbilaa. |
| Dutch - | Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-877-850-6038. |
| French - | Pour une assistance linguistique en français appeler le 1-877-850-6038 sans frais. |
| French Creole - | Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-877-850-6038 gratis. |
| German - | Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-877-850-6038 an. |
| Greek - | Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-877-850-6038 χωρίς χρέωση. |
| Gujarati - | ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-877-850-6038 પર કોલ કરો. |

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|-------------------------|--|
| Hawaiian - | No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-877-850-6038. Kāki ‘ole ‘ia kēia kōkua nei. |
| Hindi - | हन्दिी में भाषा सहायता के लए, 1-877-850-6038 पर मुफ्त कॉल करें। |
| Hmong - | Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-877-850-6038. |
| Ibo - | Maka enyemaka asụsụ na Igbo kpọọ 1-877-850-6038na akwughị ugwo o bula |
| Ilocano - | Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-877-850-6038 nga awan ti bayadanyo. |
| Italian - | Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-877-850-6038. |
| Japanese - | 日本語で援助をご希望の方は、1-877-850-6038 まで無料でお電話ください。 |
| Karen - | လၢတၢ်မၤစးတၢ်ကတိၣ်အီၣ်န့ၣ် ဂၢ်န့ၣ် နီၣ် 1-877-850-6038 လၢတၢ်အိၣ်ဒီးတၢ်လၢာ်သ့ၣ်လၢာ်စုၣ်သ့ၣ် |
| Korean - | 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-877-850-6038 번으로 전화해 주십시오. |
| Kru-Bassa - | Bɛ́m`ké gbo-kpá-kpá dyé pidyi dé Bǎswó-wuḍuiŋ wěɛ, dǎ 1-877-850-6038 |
| Kurdish - | برای راهنمایی به زبان فارسی با شماره 1-877-850-6038 به خۆراییی یه‌یوهندی بکەن. |
| Laotian - | ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ1-877-850-6038 ໂດຍບໍ່ເສຍຄ່າໄທ. |
| Marathi - | कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-877-850-6038 वर फोन करा. |
| Marshallese - | N̄an bōk jipañ ilo Kajin Majol, kallok 1-877-850-6038 ilo ejjelok wōnān. |
| Micronesian-Pohnpeyan - | Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-877-850-6038 ni sohte isais. |
| Mon-Khmer, Cambodian - | សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-877-850-6038 ដោយឥតគិតថ្លៃ។ |
| Navajo - | T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-877-850-6038 |
| Nepali - | (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1- 877-850-6038मा फोन गर्नुहोस् । |
| Nilotic-Dinka - | Tèn kuwoɲy ë thok ë Thuonjäng col 1-877-850-6038 kec'in ayöc. |
| Norwegian - | For språkassistanse på norsk, ring 1-877-850-6038 kostnadsfritt. |
| Panjabi - | ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-877-850-6038 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ। |
| Pennsylvania Dutch - | Fer Hilfe in Deutsch, ruf: 1-877-850-6038 aa. Es Aaruf koschtet nix. |
| Persian - | برای راهنمایی به زبان فارسی با شماره 1-877-850-6038 بدون هیچ هزینه ای تماس بگیرید. انگلیسی |
| Polish - | Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-877-850-6038. |

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| Portuguese - | Para obter assistência linguística em português ligue para o 1-877-850-6038 gratuitamente. |
| Romanian - | Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-877-850-6038 |
| Russian - | Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-877-850-6038. |
| Samoan - | Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-877-850-6038 e aunoa ma se totogi. |
| Serbo-Croatian - | Za jezičnu pomoć na hrvatskom jeziku pozovite besplatno broj 1-877-850-6038. |
| Spanish - | Para obtener asistencia lingüística en español, llame sin cargo al 1-877-850-6038. |
| Sudanic-Fulfude - | Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-877-850-6038. Njodi woo fawaaki on. |
| Swahili - | Ukikitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-877-850-6038 bila malipo. |
| Syriac - | ܠܚܥܠܐ ܕܥܝܢܐ ܕܡܕܢܬܐ ܕܡܕܢܬܐ ܕܡܕܢܬܐ ܕܡܕܢܬܐ ܕܡܕܢܬܐ 1-877-850-6038 ܕܡܕܢܬܐ. |
| Tagalog - | Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-877-850-6038 nang walang bayad. |
| Telugu - | భాషతో సాయం కోరకు ఎలాంటి ఖర్చు లేకుండా 1-877-850-6038 కు కాల్ చేయండి. (తెలుగు) |
| Thai - | สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-877-850-6038 ฟรีไม่มีค่าใช้จ่าย |
| Tongan - | Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-877-850-6038 ‘o ‘ikai hā ʻōtōngi. |
| Trukese - | Ren ánninnisin chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-877-850-6038 nge esapw kamé ngonuk. |
| Turkish - | (Dil) çağrısı dil yardım için. Hiçbir ücret ödemedi 1-877-850-6038. |
| Ukrainian - | Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-877-850-6038. |
| Urdu - | بلا قیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-877-850-6038 پر بات کریں۔ |
| Vietnamese - | Đề được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-877-850-6038. |
| Yiddish - | פאר שפראך הילף אין אידיש רופט 1-877-850-6038 פרי פון אפצאל. |
| Yoruba - | Fún ìrànlowo nípa èdè (Yorùbá) pe 1-877-850-6038 láí san owó kankan rárá. |