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 1-855-824-3632. 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 1-855-824-3632 to request a copy.

### Important Questions Answers Why This Matters:

<table>
<thead>
<tr>
<th>What is the overall deductible?</th>
<th>UCHP Home Host UCHP Network: Individual $0 / Family $0.</th>
<th>See the Common Medical Events chart below for your costs for services this plan covers.</th>
</tr>
</thead>
<tbody>
<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 Network (UCHP): $1,500 Individual / $3,000 Family.</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/idse/custom/uchp">http://www.aetna.com/idse/custom/uchp</a> for 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>Limitations, Exceptions &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Home Host Network Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You pay)</td>
</tr>
<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</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$45 copay/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preventive care / screening / immunization</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic drugs</td>
<td>Filled at DCAM: $5 copay/30 day prescription</td>
<td>Filled at Retail Pharmacy: $10 copay/90 day prescription</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Filled by CVS Caremark Mail Order: $20 copay/90 day prescription</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>Filled at DCAM: $15 copay/30 day prescription</td>
<td>Filled at Retail Pharmacy: $30 copay/90 day prescription</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Filled by CVS Caremark Mail Order: $60 copay/90 day prescription</td>
<td>Not covered</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>Limitations, Exceptions &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><strong>Home Host Network Provider (You will pay the least)</strong></td>
<td><strong>Out-of-Network Provider (You will pay the most)</strong></td>
</tr>
<tr>
<td>Non-preferred brand drugs</td>
<td>Filled at DCAM: $30 copay/30 day prescription $60 copay/90 day prescription</td>
<td></td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Filled at Retail Pharmacy: $45 copay/30 day prescription</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Filled by CVS Caremark Mail Order: $90 copay/90 day prescription</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>$75 copay/prescription for 30 day order</td>
<td></td>
<td>Not covered</td>
</tr>
</tbody>
</table>

**If you have outpatient surgery**

| Facility fee (e.g., ambulatory surgery center) | No charge | Not covered | None |
| Physician/surgeon fees | No charge | Not covered | None |

**If you need immediate medical attention**

| Emergency room care | $125 copay/visit | $125 copay/visit | No coverage for non-emergency use. Emergency Room copay waived if admitted. |
| Emergency medical transportation | No charge | No charge | No coverage for non-emergency transportation. |
| Urgent care | $45 copay/visit | $45 copay/visit | No coverage for non-urgent use. |

In network providers include University of Chicago Hospitals, Ingalls Quick Care (Crestwood) or CVS Minute Clinics.

**If you have a hospital stay**

<p>| Facility fee (e.g., hospital room) | $350 copay/stay | Not covered | None |
| Physician/surgeon fees | No charge | Not covered | None |</p>
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Home Host 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>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office &amp; other outpatient services: $25 copay/visit</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>$350 copay/stay</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge</td>
<td>Not covered</td>
<td>Specialist office visit copay of $45 applies for initial visit only.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$350 copay/stay</td>
<td>Not covered</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>
<td>60 visits/calendar year for Physical, Occupational &amp; Speech Therapy combined.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>No charge</td>
<td>Not covered</td>
<td>Limited to treatment of Autism.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>No charge</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>No charge</td>
<td>Not covered</td>
<td>Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>No charge</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No charge</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>$45/visit for one visit/lifetime; otherwise Not covered</td>
<td>Not covered</td>
<td>Dependents under the age of 18 years are provided one visit/lifetime to a pediatric ophthalmologist to determine the initial need for vision correction.</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered.</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</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.):

- Acupuncture
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Adult & Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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.)

- Bariatric surgery

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 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 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 1-855-824-3632.
- 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 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.
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.

<table>
<thead>
<tr>
<th>Plan</th>
<th>Peg is Having a baby (9 months of in-network pre-natal care and a hospital delivery)</th>
<th>Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia's Simple Fracture (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan's overall deductible</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Specialist copayment</td>
<td>$45</td>
<td>$25</td>
<td>$45</td>
</tr>
<tr>
<td>Hospital (facility) copayment</td>
<td>$350</td>
<td>$350</td>
<td>$125</td>
</tr>
<tr>
<td>Other copayment</td>
<td>$0</td>
<td>$10</td>
<td>$0</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
<th>What isn't covered</th>
<th>Limits or exclusions</th>
<th>The total Peg would pay is</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$0</td>
<td>$395</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$395</td>
</tr>
</tbody>
</table>

This EXAMPLE event includes services like:
- Primary care physician office visits of 3 per year (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs (4 – 90 day generic fills)
- Durable medical equipment (glucose meter)

**Total Example Cost** $7,400

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
<th>What isn't covered</th>
<th>Limits or exclusions</th>
<th>The total Joe would pay is</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$0</td>
<td>$115</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$115</td>
</tr>
</tbody>
</table>

This EXAMPLE event includes services like:
- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)
- Specialist visits (2 visits)

**Total Example Cost** $1,900

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
<th>What isn't covered</th>
<th>Limits or exclusions</th>
<th>The total Mia would pay is</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$0</td>
<td>$215</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$215</td>
</tr>
</tbody>
</table>

Note: If your plan has a wellness program and you choose to participate, you may be able to reduce your costs.

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 1-888-982-3862.

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: 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 1-800-370-4526 at no cost.

Albanian -  Për asistencë në gjithën shqip telefononi falas në 1-800-370-4526.
Amharic - እንደከበ erklä ከ ከምር ከ 1-800-370-4526 ላይ ከምር ከ
Arabic -  للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-370-4526-370-4526-
Armenian - Եջեկություն զատարելու համար կատարեք կողմնակից 1-800-370-4526 համար
Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.
Bantu-Kirundi - Niba unondera uwugufasha mu Kirundi, twakure kuni iyi numero 1-800-370-4526 ku busa
Bengali-Bangla - বাংলাদেশ ভাষা সহায়তার জন্য বিনিময় 1-800-370-4526-এ কল করুন।
Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-370-4526 nga walay bayad.
Burmese - များလေးမှားယောင်းသော်လည်း (မြန်မာစိုး) 1-800-370-4526 ကို ကြည့်ပါ။
Catalan - Per rebre assistència en (catalán), troqui al número gratuït 1-800-370-4526.
Chamorro -Para ayuda gi fino' (Chamoru), ágang 1-800-370-4526 sin gástu.
Cherokee - ᎨᏦᏨᏰprüf ᎨᏨᏰprim ᎨᏨᎦᏰᾳᏨᎦ (GWW) ᎨᏨᎦᏰfis 1-800-370-4526 0-07 y AĞAD y DEGPE hINF.Θ.
Chinese - 欲取得繁體中文語言協助，請撥打 1-800-370-4526，無需付費。
Choctaw - (Chaha) anumpa ya apela a chi | paya hinla 1-800-370-4526.
Cushite - Gargaarsa afaan Oromiffa hiktu argachuuuf lakkokeeofsa bilbila 1-800-370-4526 irrati bilisaan bilbila.
Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-370-4526.
French - Pour une assistance linguistique en français appeler le 1-800-370-4526 sans frais.
French Creole - Pou jwenn asistans nan lang Kreyol Ayisyen, rele nimewo 1-800-370-4526 gratis.
German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-370-4526 an.
Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-370-4526 χωρίς χρέωση.
Gujarati - ગુજરાતીમાં સહાયમા કારણ માટે કોઈ પણ અરજ 1-800-370-4526 પર કોઈ કરો.
No ke kōkua ma ka ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-800-370-4526. Kāki ʻole `ia keia kōkua nei.

Hindi -
हिन्दी में भाषा सहायता के लिए, 1-800-370-4526 पर मुफ्त कॉल करें।

Hmong -
Yog xav tan kev pab txhais huu Hmoob lu dawb tau zau 1-800-370-4526.

Ibo -
Maka enyemaka asụsụ na Igbo kpoọ 1-800-370-4526 na akwụghị ụgwọ ọ bụla

Ilocano -
Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-370-4526 nga awan ti bayadanyo.

Italian -
Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-370-4526.

Japanese -
日本語で援助をご希望の方は、1-800-370-4526 まで無料で電話ください。

Karen -
 особенно для пожилых людей предоставлена бесплатная услуга по телефону 1-800-370-4526.

Korean -
한국어로 언어 지원을 받고 싶으시면 무료 통화번호로 1-800-370-4526번으로 전화해 주십시오.

Kru-Bassa -
Be m'ké gbo-kpá-kpá dyé p'íyí dié Básój-wuñwúñ we, dà 1-800-370-4526

Kurdish -
برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 به خوزایی پایه‌ندی بگویید.

Laotian -
Phukhamteungphanhmsomomnyoutho lao kho muang lao 1-800-370-4526 dayny lao xangxay.

Marathi -
तीलमाहा (सराटी) सहायकासाठी 1-800-370-4526 कृतमहत्त्वकारणकाळीहाईमाध्यममोकालीकरा.

Marshallese -
Nan bok jipañ iilo Kajin Majol, kalok 1-800-370-4526 iilo ejelok wōnān.

Micronesian-
Pohnpeyan -
Ohng palien sawas en soun kawewe ni omw loka Ponape koahl 1-800-370-4526 ni sohte isais.

Mon-Khmer -
Phnompenhneuy laokha kheng laokha 1-800-370-4526 nduy laokha xhay.

Cambodian -
T'áá shi shizaad kehjí bee shiká a'doowol nínzingo Diné kehjí koji' t'áá jíik'e hóln'e' 1-800-370-4526

Navajo -
(tóíl bi) và tóíl bi 保障 語言 支援 单位 联络 1-800-370-4526 mà fóon gánúhós !

Nepali -
(Tení) मा नन्हुँलुक भाषा सहायता पाउनुका लागि 1-800-370-4526 मा फोन गर्नुहोस।

Nilotic-Dinka -
Tën kuonny ê thok ë Thuurjän col 1-800-370-4526 kecîn ayôc.

Norwegian -
For språkassistance på norsk, ring 1-800-370-4526 kostnadsfritt.

Panjabi -
ਪੰਜਾਬੀ ਦੌੜੇ ਉਪਦੱਖਾ ਮਗਰਤੀਆ ਹਿੱਸਾ, 1-800-370-4526 ਦੇ ਸ਼੍ਰੁਤਾ ਬਾਲ ਚਲਾੋ।

Pennsylvania Dutch -
Fer Helfe in Deitsch, ruf 1-800-370-4526 aa. Es Aaruf koschtet nix.

Persian -
برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 بروید. هویت به فارسی 1-800-370-4526

Polish -
Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-370-4526.
Para obter assistência linguística em português ligue para o 1-800-370-4526 gratuitamente.

Получите помощь на русском языке, позвоните по бесплатному номеру 1-800-370-4526.

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-370-4526.

Mo fesoasoani tau gagana le Gagana Samoa vala’au le 1-800-370-4526 e aunoa ma se totogi.

Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-370-4526.

Para obtener asistencia lingüística en español, llame sin cargo al 1-800-370-4526.

Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-800-370-4526. Njodi woo fawaaki on.

Ukhitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-370-4526 bila malipo.

Para sa tulong sa wika na Tagalog, tawagan ang 1-800-370-4526 nang walang bayad.

తెలుగు లో సహాయం లేదు అధ్యక్షత ప్రాంతం ని కూడా సహాయం లచ్చు ఏంటే 1-800-370-4526 అంటే చాలా లచ్చులేదు. (స్పెయియన్)

สำหรับความช่วยเหลือทางภาษาอังกฤษ คุณสามารถโทร 1-800-370-4526 ได้โดยไม่เสียค่าใช้จ่าย.

Kapau 'oko fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-800-370-4526 o 'ikai hā tōtōngi.

Ren áninnisin chikû ren (Kapasen Chuuk) kopwe kēkkēeri 1-800-370-4526 nge esapw kamé ngonuk.

(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-800-370-4526.

Щоб отримати допомогу перекладача української мови, затегелфонуйте за безкоштовним номером 1-800-370-4526.

Đẻ được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-800-370-4526.

פואר ייישור איזיס חורו 1-800-370-4526.

Fún irànlowọ nípa èdè (Yorùbá) pe 1-800-370-4526 lái san owó kankan rárà.