## Important Questions

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>In-Network: EE Only $1,500; EE+ Family $3,000. Out-of-Network: EE Only $2,175; EE+ Family $4,350.</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 policy, the overall family deductible must be met before the plan begins to pay.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. In-network preventive care is 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: EE Only $3,200; EE+ Family $6,400. Out-of-Network: EE Only $9,600; EE+ Family $19,200.</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, the overall family out–of–pocket limit must be met.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums, balance-billing charges, health care that this plan doesn't cover &amp; penalties for failure to obtain pre-authorization for services.</td>
<td>Even though you pay these expenses, they don’t count toward the out–of–pocket limit.</td>
</tr>
<tr>
<td><strong>Will you pay less if you use a network provider?</strong></td>
<td>Yes. See <a href="https://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-800-370-4526 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><strong>Do you need a referral to see a specialist?</strong></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>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>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>40% coinsurance</td>
<td>You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>20% coinsurance (retail &amp; mail order)</td>
<td>40% coinsurance after copay/prescription: 20% (retail)</td>
<td>Covers 90 day supply (retail &amp; participating mail order). Includes contraceptive drugs &amp; devices obtainable from a pharmacy, oral &amp; injectable fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-network. Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written; cost difference penalty doesn't apply to deductible or out-of-pocket limit. Deductible doesn't apply to certain preventive medications.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>20% coinsurance (retail &amp; mail order)</td>
<td>40% coinsurance after copay/prescription: 20% (retail)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>20% coinsurance (retail &amp; mail order)</td>
<td>40% coinsurance after copay/prescription: 20% (retail)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Applicable cost as noted above for generic or brand drugs</td>
<td>Not covered</td>
<td>All prescriptions must be filled through the Aetna Specialty Pharmacy Network. Precertification required for coverage.</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</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>
</tbody>
</table>
| **If you need immediate medical attention** | Emergency room care | In-Network Provider (You will pay the least): 20% coinsurance | Out-of-Network Provider (You will pay the most): 20% coinsurance | Out-of-network emergency use paid the same as in-network.  
Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except if pre-authorized.  |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | |
| | Urgent care | 20% coinsurance | 40% coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | Penalty of 50% of allowed amount for failure to obtain pre-authorization for out-of-network care. None |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office & other outpatient services: 20% coinsurance | Office & other outpatient services: 20% coinsurance | None |
| | Inpatient services | 20% coinsurance | 40% coinsurance | Penalty of 50% of allowed amount for failure to obtain pre-authorization for out-of-network care. |
| **If you are pregnant** | Office visits | No charge | 40% coinsurance | Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of 50% of allowed amount for failure to obtain pre-authorization for out-of-network care may apply. |
| | Childbirth/delivery professional services | No charge | 40% coinsurance | |
| | Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 40% coinsurance | 520 visits/calendar year combined with private-duty nursing. Penalty of 50% of allowed amount for failure to obtain pre-authorization for out-of-network care. |
| | Rehabilitation services | 20% coinsurance | 40% coinsurance | 45 visits/calendar year for Physical, Occupational & Speech Therapy combined. |
| | Habilitation services | 20% coinsurance | 20% coinsurance, except 40% coinsurance for Autism & neurodevelopmental delay | None |
### Common Medical Event Services You May Need

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>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>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
<td>90 days/calendar year. Penalty of 50% of allowed amount for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
<td>Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse. Penalty of 50% of allowed amount for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td>Hospice services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If your child needs dental or eye care

<table>
<thead>
<tr>
<th></th>
<th>Services</th>
<th>In-Network Provider</th>
<th>Out-of-Network Provider</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children's eye exam</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Children's glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Children's dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td></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)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult & Child)
- Routine foot care
- Weight loss programs

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

- Acupuncture - 12 visits/calendar year.
- Bariatric surgery - $10,000 maximum/lifetime.
- Chiropractic care - 12 visits/calendar year.
- Hearing aids - $3,000 maximum/36 months.
- Infertility treatment - For more information & exceptions, see policy document provided by your employer or call the number on your ID card.
- Private-duty nursing - Included as part of home health care.

#### 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 1-800-370-4526.
- 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 1-800-370-4526. 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**: $1,500
- **Specialist coinsurance**: 20%
- **Hospital (facility) coinsurance**: 20%
- **Other coinsurance**: 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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,750</td>
</tr>
</tbody>
</table>

**What isn't covered**
- Limits or exclusions: $60

**The total Peg would pay is**: $3,310

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

- **The plan’s overall deductible**: $1,500
- **Specialist coinsurance**: 20%
- **Hospital (facility) coinsurance**: 20%
- **Other coinsurance**: 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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$800</td>
</tr>
</tbody>
</table>

**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) coinsurance**: 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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$300</td>
</tr>
</tbody>
</table>

**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: 1-800-370-4526.

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 866-393-0002.

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, 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).
TTY: 711

Language Assistance:

For language assistance in your language call 1-800-370-4526 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-800-370-4526.
Amharic - *kît k ±ff z -= Θ z 1-800-370-4526 z, £ ōōÔ +
Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-370-4526
Armenian - Անգլերեն գործադիր աշխատատերբերության (հայերեն) համար 1-800-370-4526 կատարեն գործ:
Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.
Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-800-370-4526 ku busa
Bengali-Bangala - ৭১১ আং সাইকে জিন্দাবাদ দেওয়ানায় নোনো ১-৮০০-৩৭০-৪৫২৬
Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-370-4526 nga walay bayad.
Burmese - ဗီဒအီး အားလုံနိုင်ငံ ဗီဒီယာ 1-800-370-4526 ဒီဇိုင်း
Catalan - Per rebre assistència en (català), truqui al número gratuït 1-800-370-4526.
Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-800-370-4526 sin gåstu.
Cherokee - 26 η 2 Φ 6 Ϝ 5 5 6 6 3 Σ 6 η 2 3 $ (2 θ η) 8 8 η 6 $ 1-800-370-4526 Nj 2 $ h 6 6 6 6 5 $ 5 6 do 2.
Chinese - 欲取得繁體中文語言協助，請撥打1-800-370-4526，無需付費。
Chocotaw - (Chahta) anumpa ya apela a chi l paya hinla 1-800-370-4526.
Cushite - Gargaarsa afaan Oromiffa hiikuu argachuufl lakkokkofsa bilbilaa 1-800-370-4526 irratti bilisaan bilbilaa.
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 Kreyòl 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 - મ્યૂસારી' રુ છે' ફ્યુશ ફ્યુશ મિસાલ વ્િંગદ હો વ્િંગદ 1-800-370-4526 વિંગદ c~ c ખિંગ
Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-800-370-4526. Kākī ‘ole ‘ia kēia kōkua nei.
Hindi - 1-800-370-4526 पर मुफ्त कॉल करें।
Hmong - Yog xav tau kev txhais lus Hmoob hu dawb tau rau 1-800-370-4526.
Ibo - Maka enyemaka asụsụ na Igbo kpọọ 1-800-370-4526 na akwughị ụgwọ ọ bụla
Ilocano - Para iti tulong ti pagasaao iti pagasaao 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 まで無料でお電話ください。
Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-370-4526 번으로 전화해 주십시오.
Kru-Bassa - Bëm'kék bgo-kpá-kpá dyé pidyi ñé Baso-wuqliñ weë, daga 1-800-370-4526
Kurdish - برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 به خوراکی یاپوئندي بکان.
Laotian - 1-800-370-4526 ไวยเย่เช่ยคิ้ก.
Marathi - तंज प्राप्त करण्यासाठी मुफ्त कॉल करा 1-800-370-4526.
Marshallese - Ñan bök jipañ ilo Kajin Majol, kallok 1-800-370-4526 ilo ejjelok wōnān.
Mon-Khmer, Cambodian - 1-800-370-4526 អ៊ុំបោះដូរ។
Navajo - T'áá shi shizaad k'ehjí bee shiká a'doowol nínizingo Diné k'ehjí koji' t'áá jílk'e hólne' 1-800-370-4526
Nepali - 1-800-370-4526 मुफ्त कॉल 
Nilotic-Dinka - Tën kuonon ë thok ë Thucnjän col 1-800-370-4526 kecin ayoć.
Norwegian - For språkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt.
Panjabi - 1-800-370-4526 में कॉल करें।
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 بدون هیچ هزینه آی تماس بگیرید. انگلیسی
Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-370-4526.
Portuguese - Para obter assistência linguística em português ligue para o 1-800-370-4526 gratuitamente.
Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-800-370-4526.
То 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 besplatni 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.

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

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

 Bahamas \( \text{ɗ} \) lai san owó kankan rárá.