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 1-888-407-0427. 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 1-888-407-0427 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>For each Plan Year, In-Network: Individual $100. Out-of-Network: Individual $200.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Prescription drugs; plus in-network preventive care are covered before you meet your deductible.</td>
<td>This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a></td>
</tr>
<tr>
<td>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>In-Network: Individual $8,150/ Family $16,300. Out-of-Network: Individual $16,300</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, health care 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>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-888-407-0427 for a list of in-network providers.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>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>$25 copay/visit</td>
<td>40% coinsurance after $25 copay/visit</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$25 copay/visit</td>
<td>40% coinsurance after $25 copay/visit</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>40% coinsurance</td>
<td></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></td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>Copay/prescription, deductible doesn't apply: $15 (retail)</td>
<td>50% coinsurance, deductible doesn't apply (retail)</td>
<td>Covers 30 day supply (retail). Includes contraceptive drugs &amp; devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in-network.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>Copay/prescription, deductible doesn't apply: $40 (retail)</td>
<td>50% coinsurance, deductible doesn't apply (retail)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>Copay/prescription, deductible doesn't apply: $75 (retail)</td>
<td>50% coinsurance, deductible doesn't apply (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>Applicable cost as noted above for generic or brand drugs</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance after $150 copay/visit</td>
<td>40% coinsurance after $150 copay/visit</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 In-Network Provider (You will pay the least)</td>
<td>What You Will Pay Out-of-Network Provider (You will pay the most)</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
<td>---------------------------------------------</td>
<td>--------------------------------------------------------------</td>
<td>-----------------------------------------------------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>20% coinsurance after $250 copay/visit</td>
<td>20% coinsurance after $250 copay/visit</td>
<td>No coverage for non-emergency use.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>No coverage for non-urgent use.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance after $150 copay/visit</td>
<td>40% coinsurance after $150 copay/visit</td>
<td>Penalty of $500 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office: $25 copay/visit; Other outpatient services: 20% coinsurance</td>
<td>Office: 40% coinsurance after $25 copay/visit; Other outpatient services: 40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% coinsurance after $150 copay/visit</td>
<td>40% coinsurance after $150 copay/visit</td>
<td>Penalty of $500 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>40% coinsurance</td>
<td>Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of $500 for failure to obtain pre-authorization for out-of-network care may apply.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance after $150 copay/visit</td>
<td>40% coinsurance after $150 copay/visit</td>
<td>None</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay In-Network Provider (You will pay the least)</td>
<td>What You Will Pay Out-of-Network Provider (You will pay the most)</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
<td>--------------------------------------------</td>
<td>---------------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>60 visit per plan year.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20% coinsurance after $15 copay/visit</td>
<td>40% coinsurance after $15 copay/visit</td>
<td>Includes Physical, Occupational &amp; Speech Therapy.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>20% coinsurance after $15 copay/visit</td>
<td>40% coinsurance after $15 copay/visit</td>
<td>Penalty of $500 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>40% coinsurance</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>20% coinsurance</td>
<td>40% coinsurance</td>
<td>45 visit per plan year. Penalty of $500 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>No charge</td>
<td>40% coinsurance</td>
<td>1 routine eye exam/plan year up to age 19.</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>No charge</td>
<td>40% coinsurance</td>
<td>1 pair of glasses or lenses/plan year.</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>No charge</td>
<td>40% coinsurance</td>
<td>None</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
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- infertility treatment
- Long-term care
- Private-duty nursing
- 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
- Chiropractic care – limited to 30 visits per plan year
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) – limited to 1 routine exam per plan 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: Michigan Department of Insurance and Financial Services (DIFS), (877) 999-6442, http://www.michigan.gov/difs
• For more information on your rights to continue coverage, contact the plan at 1-888-407-0427.
• State Consumer Assistance Program, if other than state insurance department contact Michigan Health Insurance Consumer Assistance Program (HICAP), Michigan Department of Insurance and Financial Services (DIFS), P.O. Box 30220, Lansing, MI 48909-7720, (877) 999-6442, https://www.michigan.gov/difs, difs-HICAP@michigan.gov

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 1-888-407-0427.
• Michigan Department of Insurance and Financial Services (DIFS), (877) 999-6442, http://www.michigan.gov/difs
• Additionally, a consumer assistance program can help you file your appeal. Contact Michigan Health Insurance Consumer Assistance Program (HICAP), Michigan Department of Insurance and Financial Services (DIFS), P.O. Box 30220, Lansing, MI 48909-7720, (877) 999-6442, https://www.michigan.gov/difs, difs-HICAP@michigan.gov

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>Peg is Having a Baby</th>
<th>Managing Joe's type 2 Diabetes</th>
<th>Mia's Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9 months of in-network pre-natal care and a hospital delivery)</td>
<td>(a year of routine in-network care of a well-controlled condition)</td>
<td>(in-network emergency room visit and follow up care)</td>
</tr>
</tbody>
</table>

- The plan's overall deductible: $100
- Specialist copayment: $25
- 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: $12,800

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$100</td>
</tr>
<tr>
<td>Copayments</td>
<td>$50</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,530</td>
</tr>
</tbody>
</table>

What isn't covered

- Limits or exclusions: $60

The total Peg would pay is $2,740

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$100</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,000</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$300</td>
</tr>
</tbody>
</table>

What isn't covered

- Limits or exclusions: $20

The total Joe would pay is $1,420

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$100</td>
</tr>
<tr>
<td>Copayments</td>
<td>$300</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$360</td>
</tr>
</tbody>
</table>

What isn't covered

- Limits or exclusions: $0

The total Mia would pay is $760

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 1-888-407-0427.

**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: CRCordinator@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.**
For language assistance in your language call 1-888-407-0427 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-888-407-0427.

Amharic - እንግወን አማርኛ ከ 1-888-407-0427 መሆን ይደውሉ.

Arabic - 1-888-407-0427 للمشاكل في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-888-407-0427.

Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-888-407-0427 առանց գնով.

Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-407-0427 tanpa dikenakan biaya.

Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-888-407-0427 ku busa.

Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-888-407-0427-এ কল করুন।

Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-407-0427 nga walay bayad.

Burmese - 1-888-407-0427 ရှိသည်။

Catalan - Per rebre assistència en (català), truqui al número gratuït 1-888-407-0427.

Chamorro - Para ayuda gi fino' (Chamorou), ågang 1-888-407-0427 sin gástu.

Cherokee - ፤ᏍᎩᏍᎩ ᎛ᎨᏣᎦᏲ ᎮᏣᎦᏲᏰ ᎦᏣᎦᏲ (GWW) ᏣᎦᏲᏲіS 1-888-407-0427 ᏲᏣᏲ L ᏢᎦᏲᎦ I ᏢᏲᎦ I ᏢᏲᎦθ.

Chinese - 欲取得繁體中文語言協助，請撥打 1-888-407-0427，無需付費。

Choctaw - (Chahta) anumpa ya apela a chi l paya hinla 1-888-407-0427.

Cushite - Gargaarsa afaan Oromiffa hiikuu argachuu lakkoakofa bilbilaa 1-888-407-0427 irratti bilisaan bilbilaa.

Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-888-407-0427.

French - Pour une assistance linguistique en français appeler le 1-888-407-0427 sans frais.

French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-407-0427 gratis.


Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-407-0427 χωρίς χρέωση.

Gujarati - ગુજરાતીમાં લાભામાં સહાય માટે કોઈ પણ અર્થ વગર 1-888-407-0427 પર કોલ કરો.
Hawaiian -

Hindi -
हिंदी में भाषा सहायता के लिए, 1-888-407-0427 पर मुफ्त कॉल करें।

Hmong -
Maka enyemaka asusu na Igbo kpoo 1-888-407-0427 na akwughii ugwo o bu la

Ibo -
Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-407-0427 nga awan ti bayadanyo.

Ilocano -
Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-407-0427 nga awan ti bayadanyo.

Italian -
Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-407-0427.

Japanese -
日本語で援助をご希望の方は、1-888-407-0427 まで無料でお電話ください。

Karen -
Kāki ʻole ʻia kēia kōkua nei.

Korean -
한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-407-0427 번으로 전화해 주십시오.

Kru-Bassa -
1-888-407-0427

Kurdish -
1-888-407-0427

Laotian -
1-888-407-0427

Marathi -
तीलभाषा (मराठी) सहाय्यासाठी 1-888-407-0427 क्रमांकावरकोणत्याहीखिंचविषयकॉलकरा.

Marshallese -
Ñan bōk jipañ ilo Kajin Majol, kallok 1-888-407-0427 ilo ejjelok wōnān.

Micronesian-Pohnpeyan -
Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-407-0427 ni sohte isais.

Mon-Khmer, Cambodian -
1-888-407-0427

Navajo -
T’áá shi shizaad k’ehjí bee shíká a’doolwol nínízingo Diné k’ehjí koji’ t’áá jíík’e hólne’ 1-888-407-0427

Nepali -
(नेपाली) मा नि:शुल्क भाषा सहायता पाउनका लागि 1- 888-407-0427 मा फोन गर्नुहोस्।

Nilotic-Dinka -
T’en kuony ê thok ê Thuorjánh col 1-888-407-0427 kecin ayóc.

Norwegian -
For språkassistanse på norsk, ring 1-888-407-0427 kostnadsfritt.

Panjabi -
ਪੰਜਾਬੀ ਹਿੰਦੂ ਭਾਸ਼ਾ ਮਤਾਤਾ ਲਾਗਿ, 1-888-407-0427 'ੜੇ ਫੋਨ ਵਰਤੋਂ ਵਨੇ।

Pennsylvania Dutch -
Fer Helfe in Deitsch, ruf: 1-888-407-0427 aa. Es Aaruf koschtet nix.

Persian -
برای راهنمایی به زبان فارسی با شماره 1-888-407-0427 بدون هزینه ای تماس بگیرید. انگلیسی

Polish -
Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-407-0427.
Para obter assistência linguística em português ligue para o 1-888-407-0427 gratuitamente.

Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-888-407-0427

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-888-407-0427.

Mo fesoasoani tau gagana le Gagana Samoa vala’au le 1-888-407-0427 e aunoa ma se totogi.

Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-888-407-0427.

Para obtener asistencia lingüística en español, llame sin cargo al 1-888-407-0427.

Para sa tulong sa wika na Tagalog, tawagan ang 1-888-407-0427 nang walang bayad.

Para obter assistência linguística en español, llame sin cargo al 1-888-407-0427.

Fii yo on bebalal e ko yowitii e haala Pular noddee e oo numero doo 1-888-407-0427. Njodi woo fawaaki on.

Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-888-407-0427 bila malipo.

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Kapau ‘oku fiema’u hā tokoni ‘i he lea faka-Tonga telefoni 1-888-407-0427 ‘o ‘ikai hā ʻōtōngi.

Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-888-407-0427 nge esapw kamé ngonuk.

(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-888-407-0427.

Щоб отримати допомогу перекладача української мови, зазеленуйте за безкоштовним номером 1-888-407-0427.

پر پېړنې د مړي خپارې کې 1-888-407-0427 نوېږي. د سوېډیش ته په پاڼه ټولو پېړنې 1-888-407-0427.

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-888-407-0427.

אקר שפארץ הילך אל אדיש רוטן. 1-888-407-0427

Fún irànło wọ nípa èdè (Yorùbá) pe 1-888-407-0427 lái san owó kankan rárá.