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, http://www.aetnastudenthealth.com or by calling 1-877-480-4161. 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 1-877-480-4161 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 $250. Out-of-Network: Individual $1,000.</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. 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>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>Individual $4,000 / Family $6,000.</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 1-877-480-4161 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>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>In-Network Provider (You will pay the least): 25% coinsurance after $20 copay/visit</td>
<td>Out-of–Network Provider (You will pay the most): 50% coinsurance after $20 copay/visit</td>
<td>None</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>In-Network Provider (You will pay the least): 25% coinsurance after $20 copay/visit</td>
<td>Out-of–Network Provider (You will pay the most): 50% coinsurance after $20 copay/visit</td>
<td>None</td>
</tr>
<tr>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>None</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><strong>If you have a test</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td></td>
<td></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>Generic drugs</td>
<td>Copay/prescription, deductible doesn’t apply: $15 (retail)</td>
<td>Copay/prescription, deductible doesn’t apply: $15 (retail)</td>
<td>None</td>
</tr>
<tr>
<td>Preferred brand drugs</td>
<td>Copay/prescription, deductible doesn’t apply: $45 (retail)</td>
<td>Copay/prescription, deductible doesn’t apply: $45 (retail)</td>
<td>None</td>
</tr>
<tr>
<td>Non-preferred brand/generic drugs</td>
<td>Copay/prescription, deductible doesn’t apply: $60 (retail)</td>
<td>Copay/prescription, deductible doesn’t apply: $60 (retail)</td>
<td>None</td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>Copay/prescription, deductible doesn’t apply: $60 (retail)</td>
<td>Copay/prescription, deductible doesn’t apply: $60 (retail)</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency room care</td>
<td>25% coinsurance after $150 copay/visit</td>
<td>25% coinsurance after $150 copay/visit</td>
<td>No coverage for non-emergency use.</td>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td>25% coinsurance</td>
<td>25% coinsurance</td>
<td>Non-emergency transport: not covered, except if pre-authorized.</td>
</tr>
<tr>
<td>Urgent care</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
<td>No coverage for non-urgent use.</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>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>-----------------------------------</td>
<td>--------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>In-Network Provider (You will pay the least) 25% coinsurance</td>
<td>Out-of-Network Provider (You will pay the most) 50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>In-Network Provider (You will pay the least) 25% coinsurance</td>
<td>Out-of-Network Provider (You will pay the most) 50% coinsurance</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office: 25% coinsurance after $20 copay/visit; other outpatient services: 25% coinsurance</td>
<td>Office: 50% coinsurance after $20 copay/visit; other outpatient services: 50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>In-Network Provider (You will pay the least) 25% coinsurance</td>
<td>Out-of-Network Provider (You will pay the most) 50% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
</tbody>
</table>
### Common Medical Event Services You May Need

<table>
<thead>
<tr>
<th>If your child needs dental or eye care</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>Children's eye exam</td>
<td>In-Network Provider (You will pay the least): No charge</td>
<td>Out-of-Network Provider (You will pay the most): 30% coinsurance, deductible doesn't apply</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>No charge</td>
<td>30% coinsurance, deductible doesn't apply</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>No charge</td>
<td>No charge</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
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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.)**

- Chiropractic care
- Hearing aids - 1 hearing aid per ear/plan year.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.

### 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: Texas Department of Insurance, (800) 578-4677, [http://www.tdi.texas.gov/index.html](http://www.tdi.texas.gov/index.html).

- For more information on your rights to continue coverage, contact the plan at 1-877-480-4161.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [https://www.dol.gov/agencies/ebsa](https://www.dol.gov/agencies/ebsa).
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).
- 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](http://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 1-877-480-4161.
- Additionally, a consumer assistance program can help you file your appeal. Contact Texas Department of Insurance, 333 Guadalupe, Austin, TX 78701, (800) 578-4677, http://www.tdi.texas.gov/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.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan’s overall deductible**: $250
- **Specialist coinsurance**: 25%
- **Hospital (facility) coinsurance**: 25%
- **Other coinsurance**: 25%

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>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$250</td>
</tr>
<tr>
<td>Copayments</td>
<td>$40</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$3,100</td>
</tr>
</tbody>
</table>

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

**The total Peg would pay is**: $3,450

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

- **The plan’s overall deductible**: $250
- **Specialist coinsurance**: 25%
- **Hospital (facility) coinsurance**: 25%
- **Other coinsurance**: 25%

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>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$250</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,400</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**: $1,970

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

- **The plan’s overall deductible**: $250
- **Specialist coinsurance**: 25%
- **Hospital (facility) coinsurance**: 25%
- **Other coinsurance**: 25%

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>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$250</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$400</td>
</tr>
</tbody>
</table>

**What isn’t covered**:
- Limits or exclusions: $0

**The total Mia would pay is**: $650

---

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: 1-877-480-4161.

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 1-877-480-4161.

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.
TTY: 711

Language Assistance:

For language assistance in your language call 1-877-480-4161 at no cost.

Albanian - Për asistencë në gjëhën shqipe telefononi falas në 1-877-480-4161.

Amharic - እናንትንን እንደጉልች በ 1-877-480-4161 የቀደ የጆች እንፈረው እንደጉልች.

Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-877-480-4161.

Armenian - Անգլերեն ծառայության (հայերեն) համար 1-877-480-4161 խնդիր գնով.

Bahasa-Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-877-480-4161 tanpa dikenakan biaya.

Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-877-480-4161 ku busa.

Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-877-480-4161-তে কল করুন।

Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-877-480-4161 nga walay bayad.

Burmese - မိုဘာသာစာကြောင်းမှာ ဗီးယား 1-877-480-4161 ဒိုင်ပါတယ်။

Catalan - Per rebre assistència en (català), truqui al número gratuït 1-877-480-4161.

Chamorro - Para ayuda gi fino’ (Chamoru), ágang 1-877-480-4161 sin gástu.

Cherokee - ᏤᎣᏨᏯ ᎨᏰᏵᏲᏫᏤ ସେନଦ୍ୟସ ଓତି (GWAY) Ꭸମୃନେରସ 1-877-480-4161 ଓତି ଅଗୋଧ ଡେଗ୍ରାହି. ହାର୍.

Chinese - 欲取得繁體中文語言協助，請撥打 1-877-480-4161，無需付費。

Choctaw - (Chahta) anumpa ya apela a chi l paya hinla 1-877-480-4161.

Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-877-480-4161 irratti bilisaan bilbilaa.

Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-877-480-4161.

French - Pour une assistance linguistique en français appeler le 1-877-480-4161 sans frais.

French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-877-480-4161 gratis.

German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-877-480-4161 an.

Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-877-480-4161 χωρίς χρέωση.

Gujarati - ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ નંબર બાજરે 1-877-480-4161 પર કોઈ કરો.
Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-877-480-4161. Kāki ‘ole ‘ia kēia kōkua nei.

Hindi - हिन्दी में भाषा सहायता के लिए, 1-877-480-4161 पर मुफ्त कॉल करें।

Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-877-480-4161.

Ibo - Maka enyemaka asụsụ na Igbo kpọọ 1-877-480-4161 na akwụghị ụgwọ ọ bụla

Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-877-480-4161 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, puo chiamare gratuitamente 1-877-480-4161.

Japanese - 日本語で援助をご希望の方は、1-877-480-4161 まで無料でお電話ください。

Karen - နာဇာရှိသောလိုင်သောကြည့်နာဇာများကို 1-877-480-4161 မှ ရောက်လိုက်ပါ။

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-877-480-4161 번으로 전화해 주십시오.

Kru-Bassa - Ìbɛ́ m’ké gbo-kpá-kpá dyé pidiy dé Bássó-gwulín weé, dà 1-877-480-4161

Kurdish - برای راهنمایی به زبان فارسی با شماره 161480-480-4161-1 به خوایی پاموئندی بکان.

Laotian - ໂຊ້າການພັດທະນາພາສາໃຊ້ພາສາລາວ, ທ່ານຈະໃຊ້ 1-877-480-4161 ເຊັ່ນຊູທີ່ດີ.

Marathi - तीलभाषा (मराठी) सहाय्यासाठी 1-877-480-4161 क्रमांकावरकोणत्याहीखर्चाशिवाय कॉल करा.

Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-877-480-4161 ilo ejjelok wōnān.

Micronesian - Ohng palien sawas en soum kawewe ni omw lokaia Ponape koahl 1-877-480-4161 ni sohte isais.

Mon-Khmer, Cambodian - ស្ថាប័នប្រែប្រែភាសាខ្មែរ 1-877-480-4161 នៅពេលលោកបានត្រូវបានបង្កើត

Navajo - T‘áá shi shizaad k’ehji bee shiká a’doowol ninizingo Diné k’ehji koji’ t‘áá jiik’é hólne’ 1-877-480-4161

Nepali - (नेपाली) मा निषिद्धक भाषा सहायता पाउनका लागि 1-877-480-4161 मा फोन गर्नुहोस्।

Nilotic-Dinka - Tën kucoonu ë thok ë Thuonjân col 1-877-480-4161 kecín ayòc.

Norwegian - For språkassistanse på norsk, ring 1-877-480-4161 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਦੇਸ ਦੁਗਾਣਟੀ ਸਰਗੇਟਾ ਲਾਇਫ, 1-877-480-4161 ਉੱਤੇ ਮੁੱਡੁ ਲਗਪਗ ਵਧੇ।

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-877-480-4161.

Para obter assistência linguística em português ligue para o 1-877-480-4161 gratuitamente.

Представьте язык русского квалифицированной поддержки, позвоните бесплатно по номеру 1-877-480-4161.

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-877-480-4161.

Mo fesoasoani tau gagana I le Gagana Samoa vala’au le 1-877-480-4161 e aunoa ma se totogi.

Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-877-480-4161.

Para obtener asistencia lingüística en español, llame sin cargo al 1-877-480-4161.

Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-877-480-4161 Njodi woo fawaaki on.

Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-877-480-4161 bila malipo.

Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-877-480-4161 nang walang bayad.

భాషతోసాయంకొరకు�లాంటిఖర్చులేకుండ1-877-480-4161 క్రింది లాంటి ఆలంచడానికి (తెలుగు)

สำหรับความช่วยเหลือทางด้านภาษาเป็นภาษาไทยโทร 1-877-480-4161 ฟรีไม่มีค่าใช้ง่าย

Kapau ‘oku fiema’u há tokoni ‘i he lea faka-Tonga telefoni 1-877-480-4161 ‘o ‘ikai há tōtōngi.

Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe këkkëérit 1-877-480-4161 nge esapw kamé ngonuk.

(Дил) çağırtısı dil yardım için. Hiçbir ücret ödemeden 1-877-480-4161.

Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-877-480-4161.

پیام برای کانال کتنکیم ریب 1-877-480-4161 سه دسته کتنکیم و ایام یونانی ریم و در

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-877-480-4161.

Før å få råd og støtte i de 8 språk på en gratis telefon 1-877-480-4161.

Fún irànlowò nípa èdè (Yorùbá) pe 1-877-480-4161 làí sàw ọwọ kankan rará.