Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

RICE UNIVERSITY:
Open Choice® PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, https://www.aetnastudenthealth.com/ or by calling 1-877-375-7908. 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 $1,500.</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 $6,500/ Family $13,000. Out-of-Network: Individual $13,000/ Family $26,000</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 1-877-375-7908 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>

Important Questions

- What is the overall deductible?
- Are there services covered before you meet your deductible?
- Are there other deductibles for specific services?
- What is the out-of-pocket limit for this plan?
- What is not included in the out-of-pocket limit?
- Will you pay less if you use a network provider?
- Do you need a referral to see a specialist?
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>Primary care visit to treat an injury or illness</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td></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>Diagnostic test (x-ray, blood work)</td>
<td>25% coinsurance after $25 copay/visit</td>
<td>50% coinsurance after $25 copay/visit</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>25% coinsurance after $25 copay/visit</td>
<td>50% coinsurance after $25 copay/visit</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic drugs</td>
<td>Copay/prescription, deductible doesn’t apply: $20 (retail)</td>
<td>Copay/prescription, deductible doesn’t apply: $20 (retail)</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>Copay/prescription, deductible doesn’t apply: $50 (retail)</td>
<td>Copay/prescription, deductible doesn’t apply: $50 (retail)</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>Copay/prescription, deductible doesn’t apply: 50% coinsurance (retail)</td>
<td>Copay/prescription, deductible doesn’t apply: 50% coinsurance (retail)</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Copay/prescription, deductible doesn’t apply: 25% coinsurance (retail)</td>
<td>Copay/prescription, deductible doesn’t apply: 25% coinsurance (retail)</td>
</tr>
</tbody>
</table>

*Covers 30-day supply (retail). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in-network. Certain prescription drugs may require pre-authorization, contact your prescriber or pharmacist if a prescription drug requires pre-authorization.*

*For more information about limitations and exceptions, see the plan or policy document at [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com).*
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<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td><strong>Network Provider</strong> (You will pay the least): 25% coinsurance</td>
<td>Some services are subject to a 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><strong>Out-of-Network Provider</strong> (You will pay the most): 50% coinsurance</td>
<td></td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care</td>
<td>25% coinsurance after $150 copay/visit</td>
<td>No coverage for non-emergency use.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>25% coinsurance</td>
<td>Penalty of $500 for failure to obtain pre-authorization for out-of-network care for non-emergency transportation by airplane.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>25% coinsurance</td>
<td>No coverage for non-urgent use.</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>25% coinsurance</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>25% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td><strong>Office &amp; other outpatient services:</strong> 25% coinsurance</td>
<td>Some services are subject to a penalty of $500 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td><strong>Office &amp; other outpatient services:</strong> 50% coinsurance</td>
<td></td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>25% 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>25% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>25% coinsurance</td>
<td></td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Home health care</td>
<td>25% coinsurance</td>
<td>Limited to 60 visits/plan year. Penalty of $500 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>25% coinsurance</td>
<td>Includes Physical, Occupational &amp; Speech Therapy.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>25% coinsurance</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>25% 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>25% coinsurance</td>
<td>Penalty of $500 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>25% coinsurance</td>
<td></td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at www.aetnastudenthealth.com.
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</thead>
<tbody>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>Network Provider (You will pay the least): No charge</td>
<td>1 routine eye exam/plan year. Coverage through end of month turning age 19.</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Out-of-Network Provider (You will pay the most): 30% coinsurance, deductible doesn't apply</td>
<td>1 pair of glasses or lenses/plan year. Coverage through end of month turning age 19.</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>No charge</td>
<td>Limited to 2 visits every 12 months. Coverage through end of month turning age 19.</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/36 months.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.

* For more information about limitations and exceptions, see the plan or policy document at [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com).
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, 1-800-252-3439 (Consumer HelpLine), (512) 676-6000 (Local), (800) 578-4677 (Toll-Free), https://www.tdi.texas.gov/consumer/index.html.

- 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 more information on your rights to continue coverage, contact the plan at 1-877-375-7908.

- 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 Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general toll-free number at 1-877-375-7908 or Texas Department of Insurance, 1-800-252-3439, https://www.tdi.texas.gov/consumer/index.html. Additionally, a consumer assistance program can help you file your appeal. Contact Texas Department of Insurance, Consumer Protection, Mail Code 111-1A, 333 Guadalupe, P.O. Box 149091, Austin, TX 78714-9091, Phone toll-free: 1-800-318-2596, http://www.texashealthoptions.com, ConsumerProtection@tdi.texas.gov

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Not Applicable.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiljigo holne' 1-877-375-7908.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

002023-002023-029804
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** $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** $12,700

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></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

- **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** $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>$250</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,700</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 $2,270

- **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** $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>$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

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 1-877-375-7908.

**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 1-877-375-7908 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-877-375-7908.
Amharic - እንጉር ከማን ከማርያ ያለ 1-877-375-7908 ዓለም የግራ ከማርያ ያለ.
Arabic - للمساعدة في (اللغة العربية)، الارجاء الاتصال على الرقم المجاني 1-877-375-7908.
Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգ 1-877-375-7908 եայժշկ զանգ.
Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-877-375-7908 tanpa dikenakan biaya.
Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-877-375-7908 ku busa
Bengali-Bangala - বাঙলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-877-375-7908-এ কল করুন।
Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-877-375-7908 nga walay bayad.
Burmese - 1-877-375-7908 
Catalan - Per rebre assistència en (català), truqi al número gratuït 1-877-375-7908.
Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-877-375-7908 sin gåstu.
Cherokee - ᎯᏍᏗᏨᏛᏓᎨᏝᏛᏧᏗ ᎠᏨᏛᏦᏗᏛᏖ ᎠᏖᏛᏙᏛᏨᏗ (GWW) ᏩᏨᏛᏝᎨᏗ 1-877-375-7908 ƠᏗᏨᏛᏝ ᎢᏚᏨᎨ ᎦᏛᎨᏝᎨ.
Chinese - 欲取得繁體中文語言協助，請拨打 1-877-375-7908，無需付費。
Choctaw - (Chahta) anumpa ya apela a chi l paya hinla 1-877-375-7908.
Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuuf lakokkoofsa bilbilaa 1-877-375-7908 irratti bilisaan bilbilaa.
Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-877-375-7908.
French - Pour une assistance linguistique en français appeler le 1-877-375-7908 sans frais.
French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-877-375-7908 gratis.
Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-877-375-7908 χωρίς χρέωση.
Gujarati - ગુજરાતીમાં લાંબા સમય માટે હજીં પણ અર્થ વચ્ચે 1-877-375-7908 નર કોલ કરો.
Hindi - हिन्दी में भाषा सहायता के लिए, 1-877-375-7908 पर मुफ्त कॉल करें।
Hmong - Maka enyemaka asusu na Igbo kpoo 1-877-375-7908 na akwughir ugwo o bula
Ibo - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-877-375-7908 nga awan ti bayadanyo.
Ilocano - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-877-375-7908.
Japanese - 日本語で援助をご希望の方は、1-877-375-7908 まで無料でお電話ください。
Karen - ကြက်ခန်းမှ လောလောဆယ်ပေါ် ကြက်ခန်းမှ လောလောဆယ်ပေါ် ကြက်ခန်းမှ လောလောဆယ်ပေါ် ကြက်ခန်းမှ လောလောဆယ်ပေါ် ကြက်ခန်းမှ လောလောဆယ်ပေါ်
Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-877-375-7908 번으로 전화해 주십시오.
Kru-Bassa - Ñan bōk jipaŋ ilo Kajin Majol, kallon 1-877-375-7908 ilo ejelok wōnān.
Kurdish - برای مکانیزه بیابان فارسی با شماره 1-877-375-7908 به خوراکی پایه‌نهایی بکار.
Laotian - 1-877-375-7908
Marathi - कोणत्याही हिंदीशास्त्रांच्या भाषा सेवा प्राप्त करण्यासाठी, 1-877-375-7908 वर फोन करा.
Marshallese - Ohng palien sawas en sou lokaia Ponape koahl 1-877-375-7908 ni sohte isais.
Micronesian-Pohnpeyan - For språkassistanse på norsk, ring 1-877-375-7908 kostnadsfritt.
Mon-Khmer, Cambodian - Ñan bōk jipaŋ ilo Kajin Majol, kallon 1-877-375-7908 ilo ejelok wōnān.
Navajo - T'áá shi shizaad k'ehjí bee shiká a'doowol nínízingo Diné k'ehjí koji' t'áá jiík'e hólne' 1-877-375-7908
Nepali - (नेपाली) मा नि: शुल्क भाषा सहायता पाउनका लागि 1-877-375-7908 मा फोन गर्नुहोस्।
Nilotic-Dinka - Tën kuonny ê thok ê Thuonjân col 1-877-375-7908 kecín ayóc.
Panjabi - ਪੰਜਾਬੀ ਹਿੰਦੀ ਭਾਸ਼ਾ ਦੋਸੀ ਸਾਲ, 1-877-375-7908 ໄображен บูชา ว่าที่.
Persian - پارای راهنمایی به زبان فارسی با شماره 1-877-375-7908 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-877-375-7908.
Para obter assistência linguística em português ligue para o 1-877-375-7908 gratuitamente.

Pentru asistență lingvistică în română, telefonați la numărul gratuit 1-877-375-7908.

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-877-375-7908.

Mo fesoasoani tau gagana le Gagana Samoa vala‘au le 1-877-375-7908 e aunoa ma se totoni.

Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-877-375-7908.

Para obtener asistencia lingüística en español, llame sin cargo al 1-877-375-7908.

Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-877-375-7908. Njodi woo fawaaki on.

Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-877-375-7908 bila malipo.

Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-877-375-7908 nang walang bayad.

Thailand - สําหรับความช่วยเหลือทางภาษาเป็น ภาษาไทย โทร 1-877-375-7908 ฟรีไม่มีค่าใช้จ่าย

Kapau ‘oku fiema’u hā tokoni ‘i he lea faka-Tonga telefoni 1-877-375-7908 ‘o ‘ikai hā őtōngi.

Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-877-375-7908 nge esapw kamé ngonuk.

(Dil) çağrısı dil yardım için. Hiçbir ücret ödeden 1-877-375-7908.

Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-877-375-7908.

(Disappears) Blaikiyed zibyan së múntëx xëmnëtx xënaistët ko leh 1-877-375-7908. Zer bët këf.

Dé được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-877-375-7908.

Fún èrànìlòwò nípa èdè (Yorùbá) pe 1-877-375-7908 lái san owó kankan ràrà.