The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.HealthReformPlanSBC.com or by calling 1-800-826-6259. 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 1-800-826-6259 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>Individual $2,000 / Family $4,000.</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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Prescription drugs, emergency care &amp; 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>Individual $7,350 / Family $14,700.</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, certain non-essential specialty pharmacy drugs &amp; penalty for failure to obtain pre-authorization when required.</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>Not applicable.</td>
<td>This plan does not use a provider network. You can receive covered services from any provider.</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>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>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care /screening /immunization</td>
<td>No charge</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>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>Copay</td>
<td>Covers 34 day supply (retail), 35-90 day supply (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. Maintenance medications must be filled at mail after the initial retail fill.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>25% coinsurance with minimum &amp; maximum/ prescription: $25 minimum &amp; $100 maximum (retail), $45 minimum &amp; $200 maximum (mail order)</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Prescription drug coverage is administered by Express Scripts

More information about prescription drug coverage is available at

Copay max/prescription: $7.50 (retail), $15 (mail order)

Generic drugs

Preferred brand drugs

Non-preferred brand drugs
<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>Specialty drugs</td>
<td></td>
<td></td>
<td>First prescription must be filled at Express Scripts’ Specialty Pharmacy, Accredo. Subsequent fills must be through Express Scripts’ Specialty Pharmacy, Accredo. Exceptions to this policy apply for specialty medications needed within 24 hours of a hospital stay. Call Express Scripts for more information at 1-866-685-2791. Non-essential health benefit specialty drugs under the SaveonSP program do not accumulate to the out-of-pocket limit.</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$150 copay/visit, deductible doesn’t apply</td>
<td>50% coinsurance for non-emergency use.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance after $250 copay/stay</td>
<td>Pre-authorization required for care. Penalty of $500 for failure to obtain pre-authorization for care.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% 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 &amp; other outpatient services:</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20% coinsurance</td>
<td>Pre-authorization required for care. Penalty of $500 for failure to obtain pre-authorization for care.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% coinsurance after $250 copay/stay</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>Cost sharing does not apply for preventive services. Maternity care may include tests and services described</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance</td>
<td></td>
</tr>
</tbody>
</table>

*www.express-scripts.com*
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Childbirth/delivery</td>
<td>20% coinsurance</td>
<td>elsewhere in the SBC (i.e. ultrasound.) Penalty of $500 for failure to obtain pre-authorization for care may apply.</td>
</tr>
<tr>
<td>If you need help</td>
<td>facility services</td>
<td>after $250</td>
<td></td>
</tr>
<tr>
<td>recovering or have</td>
<td></td>
<td>copay/stay</td>
<td></td>
</tr>
<tr>
<td>other special</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>health needs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health care</td>
<td>20% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rehabilitation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Habilitation services</td>
<td>20% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable medical</td>
<td>20% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>equipment</td>
<td>0% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If your child needs</td>
<td>Children's eye exam</td>
<td>No charge</td>
<td>1 routine eye exam/calendar year. These expenses are available if you elect a separate vision plan. Contact SERS.</td>
</tr>
<tr>
<td>dental or eye care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children's glasses</td>
<td>Not covered</td>
<td></td>
<td>These expenses are available if you elect a separate dental plan. Contact SERS.</td>
</tr>
<tr>
<td>Children's dental</td>
<td>Not covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>check-up</td>
<td></td>
<td></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.):**

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Non-preferred brand drugs
- 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
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Private-duty nursing
- Routine eye care (Adult) - 1 routine eye exam/calendar 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:

- For more information on your rights to continue coverage, contact the plan at 1-800-826-6259.
- 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)
For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.

If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

**Your Grievance and Appeals Rights:**

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-800-826-6259.
- 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
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

**Does this plan provide Minimum Essential Coverage? Yes.**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet Minimum Value Standards? Yes.**

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

-------------------To see examples of how this plan might cover costs for a sample medical situation, see the next section.-------------------
About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

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

- The plan's overall deductible: $2,000
- 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)

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

- The plan's overall deductible: $2,000
- 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)

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

- The plan's overall deductible: $2,000
- 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**
- Peg: $12,800
- Joe: $7,400
- Mia: $1,925

**In this example, Peg would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Peg's Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,046</td>
</tr>
<tr>
<td>Copayments</td>
<td>$250</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,742</td>
</tr>
</tbody>
</table>

**What isn't covered**
- Limits or exclusions: $96

**The total Peg would pay is $3,134**

**In this example, Joe would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Joe's Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$134</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,690</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn't covered**
- Limits or exclusions: $34

**The total Joe would pay is $1,858**

**In this example, Mia would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Mia's Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,925</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

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

**The total Mia would pay is $1,925**

---

**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: 1-800-826-6259.

---

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 1-800-826-6259.

**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 (Aetna).**
TTY: 711

Language Assistance:

For language assistance in your language call 1-800-826-6259 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-800-826-6259.
Amharic - እንወስ ከማነብ እንማርሱ ከ 1-800-826-6259 ጋር ያጠቀማሌ
Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-826-6259
Armenian - Լեզվի գործիքներ պահանջում (հայերեն) զամբող 1-800-826-6259 ազատ զուգող:
Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-826-6259 tanpa dikenakan biaya.
Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-800-826-6259 ku busa
Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-800-826-6259-কে কল করুন।
Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-826-6259 nga walay bayad.
Burmese - တိုက်ခိုက်မှု အမှုထောင် ရှာဖွေရန် 1-800-826-6259မှ ခြင်းခြင်းများဖြင့် အသုံးပြုပါ။
Catalan - Per rebre assistència en (català), truqui al número gratuït 1-800-826-6259.
Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-800-826-6259 sin gåstu.
Cherokee - ႯᏨᏣᏴᏨ ᎨᏣᎳ ᎨᏣᎳ.ᏣᎳ.ᏣᎳᏨᏨᏨᏨᎵᏵᏨ (ᏣᏨᏨ) ᏢᏨᏨᏨᏨ 1-800-826-6259 揆 ᏣᎳᏨ ʃᏨᏨᏧ.ʃᏨᏨᎵ hPRʃ.
Chinese - 欲取得繁體中文語言協助，請撥打 1-800-826-6259，無需付費。
Choctaw - (Chahta) anumpa ya apela a chi l paya hinla 1-800-826-6259.
Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-800-826-6259 irratti bilisaan bilbilaa.
Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-826-6259.
French - Pour une assistance linguistique en français appeler le 1-800-826-6259 sans frais.
French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-826-6259 gratis.
German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-826-6259 an.
Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-826-6259 χωρίς χρέωση.
Gujarati - ગુજરાતીમા ભાષામા સહાય માટે ડિશ્ટ્રેક પાસ્ટર વગર 1-800-826-6259 પર કોલ કરો.
Hawaiian -
No ke kōkua ma ka 'ō lelo Hawai'i, e kahea aku i ka helu kelepona 1-800-826-6259. Kāki 'ole ia kēia kōkua nei.

Hindi -
Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-826-6259.

Hmong -
Maka enyemaka asusū na Igbo kpọọ 1-800-826-6259 na akwughì úgwọ ọ bula

Ibo -
Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-826-6259 nga awan ti bayadanyo.

Italian -
Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-826-6259.

Japanese -
日本語で援助をご希望の方は、1-800-826-6259 まで無料でお電話ください。

Karen -
秦国語で援助をご希望の方は、1-800-826-6259 まで無料でお電話ください。

Koordish -
1-800-826-6259

Laotian -
1-800-826-6259

Marathi -
तीलभाषा (मराठी) सहाय्यासाठी 1-800-826-6259 क्रमांकावरकोणत्याहीखर्चशिवायकॉलकॉलकरा.

Marshallese -
Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-826-6259 ilo ejjelok wōnān.

Micronesian- Pohnpeyan -
Ohng palien sawas en souli kawewe ni omw lokaia Ponape koahl 1-800-826-6259 ni sohte isais.

Nilotic-Dinka -
Tën ku òò ny ë thok ë Thuonjân col 1-800-826-6259 kecïn ayoc.

Norwegian -
For språkassistanse på norsk, ring 1-800-826-6259 kostnadsfritt.

Panjabi -
ਪੰਜਾਬੀ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਲਈ, 1-800-826-6259 ਵੇੜ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।

Pennsylvania Dutch -
Fer Helfe in Deitsch, ruf: 1-800-826-6259 aa. Es Aaruf koschtet nix.

Persian -
برای راهنمایی به زبان فارسی، 1-800-826-6259 به هزینه هنیزه ای تماس بگیرید. انگلیسی:
Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-826-6259.
Para obter assistência linguística em português ligue para o 1-800-826-6259 gratuitamente.

Пентру асистенţă лингвистică în româneşte telefonaţi la numărul gratuit 1-800-826-6259

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-826-6259.

Mo fesoasoani tau gagana I le Gagana Samoa vala’au le 1-800-826-6259 e aunoa ma se totogi.

За jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-826-6259.

Para obtener asistencia lingüística en español, llame sin cargo al 1-800-826-6259.

Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-800-826-6259. Njodi woo fawaaki on.

Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-826-6259 bila malipo.

Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-826-6259 nang walang bayad.

సామాన్యంగా నాటి మాంసానికి మరణించిన మొదట చెప్పించిన 1-800-826-6259 ను చేరి చేయండి. (ఇంగ్లీష్)

สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-800-826-6259 ฟรีไม่มีค่าใช้จ่าย

Kapau ‘oku fiema’u hā tokoni ‘i he lea faka-Tonga telefoni 1-800-826-6259 ‘o ‘ikai hā ʻōtōngi.

Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-800-826-6259 nge esapw kamé ngonuk.

(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-800-826-6259.

Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-826-6259.

أريد أن تكون مربية 1-800-826-6259 أن يكون نور ومنه ميتي رء ودر

Dế’ dúốc hỗ’tro ngón ngu’bang (ngón ngu’), hãy gọi miễn phí’dên số’1-800-826-6259.

אואר שפראר הייל”א היד”?ר ואליירא 1-800-826-6259

Fún iránlọwọ nipa èdè (Yorùbá) pe 1-800-826-6259 lái san owó kankan rára.