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 1-800-370-4526. 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 1-800-370-4526 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, Colorado Front Range In-Network: Individual $2,800 / Family $5,600.</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. 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>Colorado Front Range In-Network: Individual $4,000 / Family $8,000.</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 &amp; health care this plan doesn’t cover.</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 1-800-370-4526 for a list of in-network providers.</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td></td>
</tr>
</tbody>
</table>

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.

You can see the **specialist** you choose without a **referral**.
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>Colorado Front Range In-Network (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>30% coinsurance</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>30% coinsurance</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care screening immunization</td>
<td>No charge</td>
<td>Not covered</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>30% coinsurance</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>30% coinsurance</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Preferred generic drugs</td>
<td>Copay/prescription: $20 for 30 day supply, $40 for 60 day supply, $60 for 90 day supply (retail); $40 for 31-90 day supply (mail order)</td>
<td>Not covered</td>
<td>Covers 30 day supply (retail), 31-90 day supply (retail &amp; mail order). Includes contraceptive drugs &amp; devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in-network. Deductible doesn't apply to certain preventive medications.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>Copay/prescription: $40 for 30 day supply, $80 for 60 day supply, $120 for 90 day supply (retail); $80 for 31-90 day supply (mail order)</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred generic/brand drugs</td>
<td>Copay/prescription: $60 for 30 day supply, $120 for 60</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Category</td>
<td>Copay/Prescription</td>
<td>Cost Sharing</td>
<td>Notes</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>--------------------</td>
<td>--------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>Copay/prescription: 20%</td>
<td>Not covered</td>
<td>First prescription fill at a retail pharmacy or specialty pharmacy. Subsequent fills must be through the Aetna Specialty Pharmacy Network. Precertification required for coverage.</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center) 30% coinsurance</td>
<td>Not covered</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care 30% coinsurance</td>
<td>30% coinsurance</td>
<td>No coverage for non-emergency use.</td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room) 30% coinsurance</td>
<td>Not covered</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services Office &amp; other outpatient services: 30% coinsurance</td>
<td>Not covered</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits No charge</td>
<td>Not covered</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.)</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care 30% coinsurance</td>
<td>Not covered</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services 30% coinsurance</td>
<td>Not covered</td>
<td>60 visits/plan year for Physical, Occupational &amp; Speech Therapy combined.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Habilitation services 30% coinsurance</td>
<td>Not covered</td>
<td>Not covered.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care 30% coinsurance</td>
<td>Not covered</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment 30% coinsurance</td>
<td>Not covered</td>
<td>Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospice services 30% coinsurance</td>
<td>Not covered</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam No charge</td>
<td>Not covered</td>
<td>1 routine eye exam/24 months.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Children's glasses Not covered</td>
<td>Not covered</td>
<td>Not covered.</td>
<td></td>
</tr>
</tbody>
</table>
Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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 - 25 visits/plan year.
- Hearing aids - 1 hearing aid per ear/5 years for children up to age 18 & 1 hearing aid to $1,500 maximum per ear/48 months thereafter.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Private-duty nursing - 70-8 hour shifts/plan year.
- Routine eye care (Adult) - 1 routine eye exam/24 months.
- Routine eye care (Adult) - 1 routine eye exam/24 months.

Your Rights to Continue Coverage:
There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For more information on your rights to continue coverage, contact the plan at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

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

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

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-800-370-4526.
• If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/ebsa/healthreform
• For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
• Additionally, a consumer assistance program can help you file your appeal. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

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

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

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

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

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

- **The plan's overall deductible**: $2,800
- **Specialist coinsurance**: 30%
- **Hospital (facility) coinsurance**: 30%
- **Other coinsurance**: 30%

**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><strong>Deductibles</strong></td>
<td>$2,800</td>
</tr>
<tr>
<td><strong>Copayments</strong></td>
<td>$0</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>$1,200</td>
</tr>
</tbody>
</table>

**What isn't covered**: $60

**The total Peg would pay is**: $4,060

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

- **The plan's overall deductible**: $2,800
- **Specialist coinsurance**: 30%
- **Hospital (facility) coinsurance**: 30%
- **Other coinsurance**: 30%

**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><strong>Deductibles</strong></td>
<td>$2,800</td>
</tr>
<tr>
<td><strong>Copayments</strong></td>
<td>$600</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>$100</td>
</tr>
</tbody>
</table>

**What isn't covered**: $20

**The total Joe would pay is**: $3,520

---

699307-129877-139007 Page 7 of 1210
■ The plan's overall deductible $2,800
■ Specialist coinsurance 30%
■ Hospital (facility) coinsurance 30%
■ Other coinsurance 30%

This EXAMPLE event includes services like:
Emergency room care (including medical supplies)
Diagnostic test (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$2,800</th>
</tr>
</thead>
</table>

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$2,800</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What isn’t covered</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Limits or exclusions</td>
<td>$0</td>
</tr>
</tbody>
</table>

The total Mia would pay is $2,800
Assistive Technology
Persons using assistive technology may not be able to fully access the following information. For assistance, please call 866-393-0002.

Smartphone or Tablet
To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination
Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of 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 1-800-370-4526 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-800-370-4526.

Amharic - እስታ💕 እንዳንቮን ለመሳረታዊ የ назначен (1-800-370-4526) ከምነጋቱ ይጋعجب.

Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-370-4526.

Armenian - Անունը ծրագրային տեղափոխադարձ (հայերեն) քարտարագրված 1-800-370-4526 առանց գնով:

Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.

Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-800-370-4526 ku busa

Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-800-370-4526-তে কল করুন।

Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-370-4526 nga walay bayad.

Burmese - နာမည်ဖြင့် (ဝီခင်) ၏ နိုင်ငံတော် ရှိ နှစ်ပေါင်း အခြေခံ 1-800-370-4526.

Catalan - Per rebre assistència en (català), truqui al número gratuït 1-800-370-4526.

Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-800-370-4526 sin gåstu.

Cherokee - ᎠᏯᎦᏆ ᎨᏯᎲᏆ ᎠᏯᏲᏯᏦ ᎠᏦ (ᏯᏲ) ᏠᏨ᏶ᏯіᏲ 1-800-370-4526 ᎠᏦ ᐄᏦ ᐄᎦᏲ ᐄᏫ汧 ᏫᎦ.

Chinese - 欲取得繁體中文語言協助, 請撥打 1-800-370-4526, 無需付費。

Choctaw - (Chahta) anumpa ya apela a chi I paya hinla 1-800-370-4526.

Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bibilaa 1-800-370-4526 irratti bilisaan bibilaa.

Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-370-4526.

French - Pour une assistance linguistique en français appeler le 1-800-370-4526 sans frais.

French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-370-4526 gratis.

German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-370-4526 an.

Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-370-4526 χωρίς χρέωση.

Gujarati - ગુજરાતીમાં લાગ્યું સહાય માટે કોઈ પણ અર્થ વગર 1-800-370-4526 પર કોલ કરો.

Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-800-370-4526. Kāki ‘ole i kaēia kōkua nei.
Hindi - हिन्दी में भाषा सहायता के लिए, 1-800-370-4526 पर मुफ्त कॉल करें।
Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-370-4526.
Ibo - Maka enyemaka asusu na Igbo kpọọ 1-800-370-4526 na akwughị ụgwọ ọ bụla
Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-370-4526 nga awan ti bayadanyo.
Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-370-4526.
Japanese - 日本語で援助をご希望の方は、1-800-370-4526まで無料でお電話ください。
Karen - 1-800-370-4526
Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-370-4526 번으로 전화해 주십시오.
Kru-Bassa - Be'm ké gbo- kpá- kpá dyé pídyí tó Bésoo- wuquün weë, qá 1-800-370-4526
Kurdish - برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 به خورایی پایه‌ندی بکار.
Latvian - Lūklās, 1-800-370-4526
Marathi - कोणत्याही शुल्क भाषा सेवा प्राप्त करण्यासाठी, 1-800-370-4526 वर फोन करा.
Marshallese - Ny nök jipañ ilo Kajin Majol, kallok 1-800-370-4526 ilo ejjelok wōnān.
Pohnpeyan - Ohng palien sawas en sou kawewe ni omw lokaia Ponape koahl 1-800-370-4526 ni sohte isais.
Mon-Khmer, 1-800-370-4526
Cambodian - (នេះជាពិសេសនូវការជួយសម្រាប់ធ្វើការរកឃើញភាសាយដ៏សំខាន់ៗ)
Navajo - T'áá shi shizaad k'ehjí bee shiká a' doowol nínìzingo Diné k'ehjí koi' t'áá jílk'e hólne' 1-800-370-4526
Nepali - (नेपाली) मा निर्देशक भाषा सहायता पाउनका लागि 1-800-370-4526 मा फोन गर्नुहोस्।
Nilotic-Dinka - Tën kuöony ᕥ thok ê Thuonjành cól 1-800-370-4526 kecïn ayōc.
Norwegian - For språkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt.
Panjabi - (ਪੰਜਾਬੀ) ਵਿਚ ਆਦਾਨ ਕੰਮ ਚੱਲਾਉਣਾ ਲਈ 1-800-370-4526 ’ਤੇ ਮੁਫ਼ਤ ਵਰਤੋਂ ਵਾਲੀ ਜਾਂ।
Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-800-370-4526 aa. Es Aaruf koschtet nix.
Persian - برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-370-4526.

Para obter assistência linguística em português ligue para o 1-800-370-4526 gratuitamente.

Pentru asistenţă lingvistică în română, telefonați la numărul gratuit 1-800-370-4526.

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-370-4526.

Mo fesoasoani tau gagana le Gagana Samoa vala‘au le 1-800-370-4526 e aunoa ma se tootogis.

Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-370-4526.

Para obtener asistencia lingüística en español, llame sin cargo al 1-800-370-4526.

Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-800-370-4526. Njodi woo fawaaki on.

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

Para sa tulong sa wika na naso Tagalog, tawagan ang 1-800-370-4526 nang wala ng bayad.

 узнайте больше о наших услугах на тел. 1-800-370-4526.

สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-800-370-4526 ฟรีไม่มีค่าใช้จ่าย

Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-800-370-4526 ‘o ‘ikai hā ōtōngi.

Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-800-370-4526 nge esapw kamé ngonuk.

(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-800-370-4526.

Щоб отримати допомогу перекладача української мови, зв'яжіться з нами за безкоштовним номером 1-800-370-4526.

1-800-370-4526

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-800-370-4526.

היא מה אפשר קק"ק בטופס "1-800-370-4526.

Fún irànìlòwọ nípa èdè (Yorùbá) pe 1-800-370-4526 lái san òwó kankan rárá.