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, https://uchp.uchicago.edu/ or by calling 1-855-824-3632. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-888-982-3862 to request a copy.

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

**UNIVERSITY OF CHICAGO MEDICAL CENTER EMPLOYEES : Aetna SelectSM**

**Coverage Period:** 07/01/2022-06/30/2023

**Coverage for:** Individual + Family | **Plan Type:** EPO

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**Important Questions** | **Answers** | **Why This Matters:**
--- | --- | ---

**What is the overall deductible?** | Home Host Network: Individual $0/ Family $0. | See the Common Medical Events chart below for your costs for services this plan covers.

**Are there services covered before you meet your deductible?** | No. | You will have to meet the deductible before the plan pays for any services

**Are there other deductibles for specific services?** | No. | You don’t have to meet deductibles for specific services.

**What is the out-of-pocket limit for this plan?** | University of Chicago In-Network: Individual $2,500 / Family $5,000. | 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.

**What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges & health care this plan doesn't cover. | Even though you pay these expenses, they don’t count toward the out–of–pocket limit.

**Will you pay less if you use a network provider?** | Yes. See [http://www.aetna.com/dse/custom/uchp](http://www.aetna.com/dse/custom/uchp) Primary Car Provider (PCP) selection or call 1-855-824-3632 for a list of UCHP In Network providers. Your PCP will handle all referrals to a network specialist. | This plan uses a provider network limited to the University of Chicago Medical Center and Ingalls providers covered under the UCHP Health Plan. There is no coverage outside of the UCHP network.

**Do you need a referral to see a specialist?** | Yes. | This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the 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>University of Chicago In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><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>$20 copay/visit</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$30 copay/visit</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>None</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>10% coinsurance</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% coinsurance</td>
<td>Not covered</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></td>
<td></td>
</tr>
<tr>
<td>More information about <strong>prescription drug coverage</strong> is available at <a href="http://www.aetna.com/pharmacy-">www.aetna.com/pharmacy-</a></td>
<td>Generic drugs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Filled at DCAM/Ingalls: $5 copay/30 day prescription $10 copay/90 day prescription</td>
<td>Not covered</td>
<td>Maintenance Medications should be filled using Duchossois Center for Advanced Medicine (DCAM) Outpatient Pharmacy or Ingalls Outpatient Pharmacy locations.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Filled at Retail Pharmacy: $15 copay/30 day prescription</td>
<td></td>
<td>Allowed to fill a 30-day supply of a maintenance medication twice at a retail pharmacy. After that, you must get a 90-day supply at UCM DCAM/Ingalls (retail or mail)</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>University of Chicago In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>------------------------------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>insurance/individuals-families</td>
<td>Preferred brand drugs</td>
<td>Filled at DCAM/Ingalls: $15 copay/30 day prescription $30 copay/90 day prescription</td>
<td>Not covered</td>
<td>Drugs used for treatment of infertility, impotence and smoking deterrents have plan limitations (i.e. drugs used for the treatment of infertility are covered at 75% of cost)</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>Filled at DCAM/Ingalls: $30 copay/30 day prescription $60 copay/90 day prescription</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Filled at Retail Pharmacy: $35 copay/30 day prescription</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Filled at Retail Pharmacy: $60 copay/30 day prescription | Not covered | |
<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></td>
<td>University of Chicago In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>Specialty drugs</td>
<td></td>
<td>Same as above for applicable formulary. Specialty medications must be filled at the UCM Specialty Pharmacy. If the UCM Specialty Pharmacy is unable to fill your prescription, you may use CVS Specialty. UCM DCAM/Ingalls pricing will be honored</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$175 copay/visit</td>
<td>$175 copay/visit</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$30 copay/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Covered 100%, no copay</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>Covered 100%</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

---

If you have outpatient surgery:
- Facility fee (e.g., ambulatory surgery center): 10% coinsurance
- Physician/surgeon fees: 10% coinsurance

If you need immediate medical attention:
- Emergency room care: $175 copay/visit
- Emergency medical transportation: 10% coinsurance
- Urgent care: $30 copay/visit

If you have a hospital stay:
- Facility fee (e.g., hospital room): 10% coinsurance
- Physician/surgeon fees: 10% coinsurance

If you need mental health, behavioral health, or substance abuse services:
- Outpatient services: Covered 100%, no copay
- Inpatient services: Covered 100%

If you are pregnant:
- Office visits: No charge
<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>
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<tbody>
<tr>
<td></td>
<td></td>
<td>University of Chicago In-Network Provider (You will pay the least)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Out-of-Network Provider (You will pay the most)</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Childbirth/delivery professional services</td>
<td>10% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>10% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Home health care</td>
<td>10% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>10% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>10% coinsurance, except no charge for Autism</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>10% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>10% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>10% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>Not covered</td>
<td>Not covered</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
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Hearing aids
- 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.)

- Bariatric surgery
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition, artificial insemination, ovulation induction & advanced reproductive technology - 4 attempts per lifetime

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 1-855-824-3632.
- 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](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](http://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](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 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 1-855-824-3632.
- 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](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](http://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](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: **$0**
- Specialist copayment: **$30**
- Hospital (facility) coinsurance: **10%**
- Other coinsurance: **10%**

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)

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$12,700</th>
</tr>
</thead>
<tbody>
<tr>
<td>In this example, Peg would pay:</td>
<td></td>
</tr>
<tr>
<td>Cost Sharing</td>
<td></td>
</tr>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$30</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,200</td>
</tr>
<tr>
<td>What isn't covered</td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$0</td>
</tr>
<tr>
<td>The total Peg would pay is</td>
<td><strong>$1,230</strong></td>
</tr>
</tbody>
</table>

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

- The plan's overall deductible: **$0**
- Specialist copayment: **$30**
- Hospital (facility) coinsurance: **10%**
- Other coinsurance: **10%**

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)

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$5,600</th>
</tr>
</thead>
<tbody>
<tr>
<td>In this example, Joe would pay:</td>
<td></td>
</tr>
<tr>
<td>Cost Sharing</td>
<td></td>
</tr>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$18</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$200</td>
</tr>
<tr>
<td>What isn't covered</td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$0</td>
</tr>
<tr>
<td>The total Joe would pay is</td>
<td><strong>$380</strong></td>
</tr>
</tbody>
</table>

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

- The plan's overall deductible: **$0**
- Specialist copayment: **$30**
- Hospital (facility) coinsurance: **10%**
- Other coinsurance: **10%**

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>
<tbody>
<tr>
<td>In this example, Mia would pay:</td>
<td></td>
</tr>
<tr>
<td>Cost Sharing</td>
<td></td>
</tr>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$205</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$150</td>
</tr>
<tr>
<td>What isn't covered</td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$0</td>
</tr>
<tr>
<td>The total Mia would pay is</td>
<td><strong>$355</strong></td>
</tr>
</tbody>
</table>

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 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 1-888-982-3862 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-888-982-3862.
Amharic - እኔት ከንግዜም ያልጭሚያቸው ከ ከጠmodulo ከ 1-888-982-3862 እኔታ ያለባቸው.
Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-888-982-3862
Armenian - Անբիզնեսներ ընդունեն լեզու հայերեն (հայերեն) քաղաք 1-888-982-3862 անվճար գրություն.
Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya.
Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-888-982-3862 ku busa
Bengali-Bangla - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে লয় 1-888-982-3862-এত কল করন।
Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-982-3862 nga walay bayad.
Burmese - 1-888-982-3862
Catalan - Per rebre assistència en (català), truqui al número gratuït 1-888-982-3862.
Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-888-982-3862 sin gástu.
Cherokee - ፤Disposed ከተመለከት ይግ ISR (CWY) የበገር 1-888-982-3862 መወን ምስ ከገር ከምር.
Chinese - 欲取得繁體中文語言協助，請撥打 1-888-982-3862，無需付費。
Choctaw - (Chahta) anumpa ya apela a chi l paya hinla 1-888-982-3862.
Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-888-982-3862 irratti bilisaa bilbilaa.
Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-888-982-3862.
French - Pour une assistance linguistique en français appeler le 1-888-982-3862 sans frais.
French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-982-3862 gratis.
German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-982-3862 an.
Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-982-3862 χωρίς χρέωση.
Gujarati - જરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ભાષુ પણ પણ 1-888-982-3862 પર કોલ કરો.
Hindi - 1-888-982-3862 पर मुफ्त कॉल करें।

Hmong - Yog xav tau kev txhais lus Hmoob hu dawb tau rau 1-888-982-3862.

Ibo - Maka enyemaka asusu na Igbo kpọọ 1-888-982-3862 na akwughị ụgwọ ọ bula

Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-982-3862 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-982-3862.

Japanese - 日本語で援助をご希望の方は、1-888-982-3862 まで無料でお電話ください。

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862 번으로 전화해 주십시오.

Kru-Bassa - Be m’ké gbo-kpá-kpá dyé pidyi dié Báso–wuquet wëè, dë 1-888-982-3862

Kurdish - برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 به خورایی بی‌توجهی بکار.

Laotian - 1-888-982-3862.

Marathi - कंठेच भाषा वाचनाचे प्रश्न करण्यासाठी, 1-888-982-3862 वर फोन करा.

Marshallese - 1-888-982-3862 ilo ejjelok wōnān.

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Mon-Khmer, Cambodian - 1-888-982-3862

Navajo - T'áá shi shizaad k'ehji bee shiká a'doowol nínizingo Diné k'ehji kojí' t'áá jíík'e hólne' 1-888-982-3862

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Norwegian - For språkassistanse på norsk, ring 1-888-982-3862 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਪਾਉਣਕਾ ਲਾਗਣਾ 1-888-982-3862 ਦੂਸਰੀ ਸਥਿਤੀ,


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Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-982-3862.

Portuguese - Para obter assistência linguística em português ligue para o 1-888-982-3862 gratuitamente.

Romanian - Pentru asistenţă lingvistică în română telefonați la numărul gratuit 1-888-982-3862.
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Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-888-982-3862 nge esapw kamé ngonuk.

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Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí số điện thoại 1-888-982-3862.

Fører, velkommen til norsk. 1-888-982-3862

Fún irànìlòwò nípa èdè (Yorùbá) pe 1-888-982-3862 lái san owó kankan rárá.