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 1-877-626-2314. 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 1-877-626-2314 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 $300. Out-of-Network: Individual $600.</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 $2,500 / Family $5,000. Out-of-Network: Individual NONE / Family NONE.</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 1-877-626-2314 for a list of in-network providers.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<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>40% coinsurance after $20 copay/visit</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>20% coinsurance</td>
<td>40% coinsurance after $20 copay/visit</td>
</tr>
<tr>
<td></td>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>40% coinsurance after $20 copay/visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% coinsurance</td>
<td>40% coinsurance after $20 copay/visit</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>40% coinsurance after $20 copay/visit</td>
</tr>
</tbody>
</table>
### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>What You Will Pay In-Network Provider (You will pay the least)</th>
<th>What You Will Pay 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 need drugs to treat your illness or condition</strong></td>
<td>Copay/prescription, deductible doesn't apply: $10 (retail) &amp; $25 (mail order)</td>
<td>50% coinsurance after copay/prescription, deductible doesn't apply: $10 (retail)</td>
<td>Covers 30 day supply (retail), 31-90 day supply (retail &amp; 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 in-network.</td>
</tr>
<tr>
<td>Generic drugs</td>
<td>Copay/prescription, deductible doesn't apply: $30 (retail) &amp; $75 (mail order)</td>
<td>50% coinsurance after copay/prescription, deductible doesn't apply: $30 (retail)</td>
<td></td>
</tr>
<tr>
<td>Preferred brand drugs</td>
<td>Copay/prescription, deductible doesn't apply: $60 (retail) &amp; $150 (mail order)</td>
<td>50% coinsurance after copay/prescription, deductible doesn't apply: $60 (retail)</td>
<td></td>
</tr>
<tr>
<td>Non-preferred brand drugs</td>
<td>Applicable cost as noted above for generic or brand drugs</td>
<td>Applicable cost as noted above for generic or brand drugs</td>
<td></td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>Applicable cost as noted above for generic or brand drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>Facility fee</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care</td>
<td>20% coinsurance after $100 copay/visit</td>
<td>20% coinsurance after $100 copay/visit</td>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Urgent care</td>
<td>20% coinsurance</td>
<td>40% coinsurance after $20 copay/visit</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>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>Facility fee</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay In-Network Provider (You will pay the least)</td>
<td>What You Will Pay Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------------------------------------------------</td>
<td>-------------------------------------------------------------</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office: 20% coinsurance, maximum patient responsibility of $20 per visit, deductible doesn't apply; Other outpatient services: 20% coinsurance, deductible doesn’t apply</td>
<td>Office: 20% coinsurance, after $20 copay/visit, deductible doesn’t apply; Other outpatient services: 40% coinsurance, deductible doesn’t apply</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% coinsurance, deductible doesn’t apply</td>
<td>40% coinsurance, deductible doesn’t apply</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>40% coinsurance after $20 copay/visit</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance, deductible doesn’t apply</td>
<td>40% coinsurance, deductible doesn’t apply</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance, deductible doesn’t apply</td>
<td>40% coinsurance, deductible doesn’t apply</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% coinsurance,</td>
<td>40% coinsurance,</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20% coinsurance</td>
<td>40% coinsurance after $20 copay/visit</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>20% coinsurance</td>
<td>40% coinsurance after $20 copay/visit</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>40% coinsurance after $20 copay/item</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay In-Network Provider (You will pay the least)</td>
<td>What You Will Pay Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>---------------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>No charge</td>
<td>40% coinsurance, deductible doesn't apply</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>No charge</td>
<td>40% coinsurance, deductible doesn't apply</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>No charge</td>
<td>40% coinsurance</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)
- Long-term care
- 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.):**

- Abortion
- Bariatric surgery
- Chiropractic care
- Hearing aids - 1 hearing aid per ear/24 months.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
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: Illinois Department of Insurance, Office of Consumer Health Insurance, 1-877-527-9431 toll free, 1-866-323-5321 (TDD), http://insurance.illinois.gov/.
- For more information on your rights to continue coverage, contact the **plan** at 1-877-626-2314.

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 1-877-626-2314.
- Additionally, a consumer assistance program can help you file your **appeal**. Contact Office of Consumer Health Insurance, Consumer Services Section, 122 South Michigan Avenue, 19th floor, Chicago, IL 60603, Or 320 W. Washington Street, Springfield, IL 62767-0001, 877-527-9431, 1-866-323-5321 (TDD), http://insurance.illinois.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? **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 $300
- 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)

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>$300</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,600</td>
</tr>
</tbody>
</table>

What isn't covered
- Limits or exclusions $60
The total Peg would pay is $1,960

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

- The plan’s overall deductible $300
- 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)

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>$300</td>
</tr>
<tr>
<td>Copayments</td>
<td>$400</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$100</td>
</tr>
</tbody>
</table>

The total Joe would pay is $820

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

- The plan’s overall deductible $300
- 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 $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>$300</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$500</td>
</tr>
</tbody>
</table>

What isn't covered
- Limits or exclusions $0
The total Mia would pay is $800

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 1-877-626-2314.

**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 1-877-626-2314 at no cost.

**Albanian** - Për asistencë në gjuhën shqipe telefononi falas në 1-877-626-2314.

**Amharic** - ከቀረበውን ከንግድምነት ያስፋገርምጉን (ሁምባት) ያ الاحتلال 1-877-626-2314 መስጠቱ ውስጥ.

**Arabic** - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-877-626-2314.

**Armenian** - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-877-626-2314 առանց գնով:

**Bahasa Indonesia** - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-877-626-2314 tanpa dikenakan biaya.

**Bantu-Kirundi** - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-877-626-2314 ku busa

**Bengali-Bangala** - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-877-626-2314-তে কল করুন।

**Bisayan-Visayan** - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-877-626-2314 nga walay bayad.

**Burmese** - မြန်မာစိုးရိမ် အသေးစိုးမှုများအတွက် 1-877-626-2314 အားလုံးကို အသုံးပြုပါ။

**Catalan** - Per rebre assistència en (català), truqui al número gratuït 1-877-626-2314.

**Chamorro** - Para ayuda gi fino' (Chamoru), ågang 1-877-626-2314 sin gástu.

**Cherokee** - ᏣᎳᎩ ᎦᏬᏂᎯᏍᏗ ᏗᏯᏍᏗᏍᎩ ᏣᏰᏍᏗ 1-877-626-2314 ᏤᏳᎦ Ꮳ ᎜ᏳᎦ ᎠᏗᏪᏗ ᏧᏦᏗ 𨨓.

**Chinese** - 欲取得繁體中文語言協助，請撥打 1-877-626-2314，無需付費。

**Choctaw** - (Chahta) anumpa ya apela a chi l paya hinla 1-877-626-2314.

**Cushite** - Gargaarsa afaan Oromiffa hiikuu argachuuf lakokkofsa bilbilaa 1-877-626-2314 irratti bilisaan bilbilaa.

**Dutch** - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-877-626-2314.

**French** - Pour une assistance linguistique en français appeler le 1-877-626-2314 sans frais.

**French Creole** - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-877-626-2314 gratis.

**German** - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-877-626-2314 an.

**Greek** - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-877-626-2314 χωρίς χρέωση.

**Gujarati** - ગુજરાતીમાં લાઇન સહાય માટે કોઈ પણ અર્થ વગર 1-877-626-2314 પર કોલ કરો.
No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-877-626-2314. Kāki ‘ole ‘ia kēia kōkua nei.

Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-877-626-2314.

Maka enyemaka asusu na Igbo kpọọ 1-877-626-2314 na akwughi ụgwọ ọ bula

Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-877-626-2314 nga awan ti bayadanyo.

Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-877-626-2314.

日本語で援助をご希望の方は、1-877-626-2314 まで無料でお電話ください。

한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-877-626-2314 번으로 전화해 주십시오.

Be&m ké gbo-kpá-kpá dyé pidyi dè Baso-wuquün weę, dà 1-877-626-2314

برای راهنمایی به زبان فارسی با شماره 1-877-626-2314 به حوزه پایه‌ی پایداری بکنی.

日本語で援助をご希望の方は、1-877-626-2314 まで無料でお電話ください。

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1-877-626-2314

کورستان می‌توانید با همکاری تلفنی، 1-877-626-2314 به صحبت نقد کنید.

日本語で援助をご希望の方は、1-877-626-2314 まで無料でお電話ください。

한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-877-626-2314 번으로 전화해 주십시오.

Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-877-626-2314 nga awan ti bayadanyo.

For språkassistanse på norsk, ring 1-877-626-2314 kostnadsfritt.

Fer Helfe in Deitsch, ruf: 1-877-626-2314 aa. Es Aaruf koschtet nix.

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-877-626-2314.
Para obter assistência linguística em português ligue para o 1-877-626-2314 gratuitamente.

Pentru asistență lingvistică în româneste telefonați la numărul gratuit 1-877-626-2314

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-877-626-2314.

Mo fesoasoani tau gagana I le Gagana Samoa val'a au le 1-877-626-2314 e aunoa ma se tokotog.

Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-877-626-2314.

Para obtener asistencia lingüística en español, llame sin cargo al 1-877-626-2314.

Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-877-626-2314. Njodi woo fawaaki on.

Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-877-626-2314 bila malipo.

Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-877-626-2314 nang walang bayad.

สำหรับความช่วยเหลือทางภาษาเป็นภาษาไทยโทร 1-877-626-2314 ฟรีไม่มีค่าใช้จ่าย

Kapau ‘oku fiema’u hā tokoni ‘i he lea faka-Tonga telefoni 1-877-626-2314 ‘o ‘ikai hā őtōngi.

Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékquéeri 1-877-626-2314 nge esapw kamé ngonuk.

(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-877-626-2314.

Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-877-626-2314.

Dế’duọc hơ’trố’ng nguyễn bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-877-626-2314.

Fún irànìfọ̀wọ́ nípa èdè (Yorùbá) pe 1-877-626-2314 lái san owó kankan rárá.