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, contact HR Services at 814-865-1473. 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/](https://www.healthcare.gov/sbc-glossary/) or call 814-865-1473 to request a copy.

### Important Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall <strong>deductible</strong>?</td>
<td>$1,600 individual/$3,200 family – In-network</td>
<td>You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.</td>
</tr>
<tr>
<td></td>
<td>$3,200 individual/$6,400 family – Out-of-network</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The deductible does not apply to preventive services.Coinsurance amounts do not apply toward the deductible.</td>
<td></td>
</tr>
<tr>
<td>Are there services covered before you meet your <strong>deductible</strong>?</td>
<td>Yes. Preventive services.</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.</td>
</tr>
<tr>
<td>Are there other <strong>deductibles</strong> for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.</td>
</tr>
<tr>
<td>What is the <strong>out-of-pocket limit</strong> for this <strong>plan</strong>?</td>
<td>$3,575 individual/$7,150 family – In-network</td>
<td>The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</td>
</tr>
<tr>
<td></td>
<td>$7,150 individual/$14,300 family – Out-of-network</td>
<td></td>
</tr>
<tr>
<td>What is not included in the <strong>out-of-pocket limit</strong>?</td>
<td>Premiums, balance-billed charges, and health care this plan does not cover do not apply to your total out of pocket limit.</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 <strong>network provider</strong>?</td>
<td>Yes. For a list of in-network providers, visit Aetna’s DocFind at <a href="http://ohr.psu.edu/benefits">http://ohr.psu.edu/benefits</a> or the public DocFind at <a href="http://www.aetna.com">www.aetna.com</a>. You can also call the Penn State Aetna Concierge Team at 1-855-878-4197.</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 <strong>referral</strong> to see a <strong>specialist</strong>?</td>
<td>No.</td>
<td>You can see the specialist you choose without permission from this plan.</td>
</tr>
</tbody>
</table>
### Summary of Benefits and Coverage

*What this Plan Covers & What You Pay For Covered Services*

**Coverage Period:** 01/01/2019 – 12/31/2019

**Coverage for:** Individual & Family | **Plan Type:** HDHP

---

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td><strong>Specialist visit</strong></td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td><strong>Preventive care/screening/immunization</strong></td>
<td>No Charge for preventive services</td>
<td>30% coinsurance for preventive services</td>
<td>One routine physical per calendar year. Please refer to your preventive schedule for additional information.</td>
</tr>
</tbody>
</table>

**If you have a test**

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnostic test</strong> (x-ray, labs / blood work)</td>
<td>10% coinsurance (X-Ray) 10% coinsurance (Labs/Blood work - Quest/LabCorp) 30% coinsurance (Labs/Blood work – Freestanding lab, facility or hospital)</td>
<td>30% coinsurance (X-Ray) 50% coinsurance (Labs/Blood work)</td>
<td>Labs/Blood work as part of emergency room or inpatient hospital do not apply. Please refer to emergency room or inpatient hospital benefit section on this Summary Benefits of Coverage.</td>
</tr>
<tr>
<td><strong>Imaging (CT/PET scans, MRIs)</strong></td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>Requires pre-approval by the plan.</td>
</tr>
</tbody>
</table>

**If you need drugs to treat your illness or condition**

More information about prescription drug coverage is available at [www.caremark.com](http://www.caremark.com) or by calling 844-462-0203

<table>
<thead>
<tr>
<th>Tier</th>
<th>Typically</th>
<th>Retail</th>
<th>Mail</th>
<th>Not covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1- Typically Generic drugs</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 2- Typically Preferred brand drugs</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 3- Typically Non-</td>
<td>40% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

*Questions:* Call HR Services at (814) 865-1473 or visit us at [http://ohr.psu.edu/benefits](http://ohr.psu.edu/benefits).
### Summary of Benefits and Coverage

**What this Plan Covers & What You Pay For Covered Services**

**The Pennsylvania State University: PPO Savings**

**Coverage Period:** 01/01/2019 – 12/31/2019

**Coverage for:** Individual & Family | **Plan Type:** HDHP

<table>
<thead>
<tr>
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<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preferred drug</td>
<td>Specialty drugs</td>
</tr>
<tr>
<td>preferred brand drugs</td>
<td></td>
<td></td>
<td>Not covered</td>
</tr>
<tr>
<td>Specialty drugs</td>
<td></td>
<td>Preferred- 20% coinsurance with a $65 minimum</td>
<td>Specialty drugs must be purchased through CVS Caremark Specialty Pharmacy. Maximum allowed per prescription is 31 days. Prescription coinsurance amounts paid are included in the deductible. Dispense as written penalties apply when the member request no substitution.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-Preferred- 40% coinsurance with a $100 minimum</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Urgent care</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
</tbody>
</table>

**Questions:** Call HR Services at (814) 865-1473 or visit us at [http://ohr.psu.edu/benefits](http://ohr.psu.edu/benefits).
## Summary of Benefits and Coverage

What this Plan Covers & What You Pay For Covered Services

### The Pennsylvania State University: PPO Savings

**Coverage Period:** 01/01/2019 – 12/31/2019

**Coverage for:** Individual & Family | **Plan Type:** HDHP

<table>
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<tr>
<th>Common Medical Event</th>
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<th>Limitations, Exceptions, &amp; Other Important Information</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td>services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td><strong>Home health care</strong></td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td><strong>Rehabilitation services</strong></td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td><strong>Habilitation services</strong></td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td><strong>Skilled nursing care</strong></td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td><strong>Durable medical equipment</strong></td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td><strong>Hospice services</strong></td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td><strong>Children’s eye exam</strong></td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Children’s glasses</strong></td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Children’s dental check-up</strong></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
- Habilitation Services
- Routine foot care
- Cosmetic Surgery
- Long-term care
- Weight loss programs

**Questions:** Call HR Services at (814) 865-1473 or visit us at [http://ohr.psu.edu/benefits](http://ohr.psu.edu/benefits).
Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
The Pennsylvania State University: PPO Savings

Coverage Period: 01/01/2019 – 12/31/2019
Coverage for: Individual & Family | Plan Type: HDHP

Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)

<table>
<thead>
<tr>
<th>Coverage Provided</th>
<th>Bariatric Surgery (requires pre-approval)</th>
<th>Hearing aids</th>
<th>Non-emergency care when traveling outside the U.S. (subject to deductible/coinsurance and balance billing)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Chiropractic Care</td>
<td>Infertility treatment (requires pre-approval)</td>
<td>Private-duty nursing</td>
</tr>
<tr>
<td></td>
<td>Coverage provided outside the United States</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Your Rights to Continue Coverage:
If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact Aetna at 1-855-878-4197. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: Aetna at 1-855-878-4197. You may also contact the Department of Labor’s Employee Benefits Security Administration at 1-866-444-4BSA (3272) or www.dol.gov/ebda/healthreform.

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 the 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** $1600
- **Specialist** coinsurance 10%
- **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)*

**Total Example Cost** $12,600

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

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,600</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,300</td>
</tr>
</tbody>
</table>

**What isn't covered**

- Limits or exclusions $100

**The total Peg would pay** $3,000

---

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

- The **plan's overall deductible** $1600
- **Specialist** coinsurance 10%
- **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)*

**Total Example Cost** $7,000

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

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,600</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$100</td>
</tr>
</tbody>
</table>

**What isn't covered**

- Limits or exclusions $4,300

**The total Joe would pay** $6,000

---

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

- The **plan's overall deductible** $1600
- **Specialist** coinsurance 10%
- **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)*

**Total Example Cost** $1,800

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

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,600</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$200</td>
</tr>
</tbody>
</table>

**What isn't covered**

- Limits or exclusions $0

**The total Mia would pay** $1,800

---

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 1-800-370-4526.

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 on the basis of race, color, national origin, age, disability, or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aetna:
• Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  ○ Qualified sign language interpreters
  ○ Written information in other formats (large print, audio, accessible electronic formats, other formats)

• Provides free language services to people whose primary language is not English, such as:
  ○ Qualified interpreters
  ○ Information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 14462, Lexington, KY 40512, 1-800-648-7817, TTY 711, Fax 859-425-3379, CRCordinator@aetna.com.

California HMO/HMO Members: Civil Rights Coordinator, PO Box 24030 Fresno CA, 93779, 1-800-648-7817, TTY 711, Fax 860-262-7705, CRCordinator@aetna.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (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 - ከልማር ክም እ ከልማር ከ 1-800-370-4526 መ እ ከልማር.

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

Armenian - Նախագահ էջում էջում էջ էջ էջ էջ էջ էջ 1-800-370-4526 Բացիկ վագն.

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

Bantu-Kirundi - Niba wondenza urugufasha mu Kirundi, twakure kuki yiy numero 1-800-370-4526 ku buza

Bengali-Bangala - বাংলা ভাষা সহায়তার জন্য বিনিময় 1-800-370-4526 ভূক করুন।

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

Burmese - မြန်မာစိုက်ပျိုးနာမှုနာမှု ထိုသော်အ 1-800-370-4526 ချင်တကှ.

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

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

Cherokee - ᖇᏖᏔ ᎑ᎣᏗᏔ ᏖᎾᎣᎳᏔ ᎑ᏗᏔᏗ (GWAY) ᏕᏗᏔᏗᏔS 1-800-370-4526 O-OṬ ᎩᏔᎣ ᎠᏔᎣ JEG.Pr H-KO.

Chinese - 汬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 l paya hinla 1-800-370-4526.

Cushite - Gargaarsa afaan Oromiffa hiiku argachuu waxakkosha bilbilaa 1-800-370-4526 irraati bilisaan bilbilaa.

Dutch - Bel voor tolk- en vertaalzaken 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 assistans 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 ભાષાના સહાય માટે કોઈ પણ અર્થવિભાગ 1-800-370-4526 પર કોઈ કરો.
No ke kōkua ma ka ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-800-370-4526. Kāki ʻole ʻia kēia kōkua nei.

Hindi -
हिन्दी में भाषा सहायता के लिए, 1-800-370-4526 पर मुफ्त कॉल करें।

Hmong -
Yog xav tau kev pab txhais hua Hmooob hlu dawb tau rau 1-800-370-4526.

Ibo -
Maka enyemaka asụsụ na Igbo kpọọ 1-800-370-4526 na akwụṣi 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 -
သင်္ကြန်သည် မှတ်ချက်ပြုသည် နောက်ပိုင်း 1-800-370-4526 ကို သို့လှူပါစေ။

Korean -
한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-370-4526번으로 전화해 주십시오.

Kru-Bassa -
Bëm‘ké gbo-kpá-kpá dyé pidyé qé Başo–wuqùûn wëé, qá 1-800-370-4526

Kurdish -
پریا راهنمایی به زبان فارسی با شماره 1800-370-4526 به خویرایی پیامده پیام.

Laotian -
ເກ泰国odynamic_clockwise_1_800_370_4526 တိုးတက်ကြားနေပါသည်။

Marathi -
तीलभाषा (मराठी) सहायता 1-800-370-4526 करुणाकारकोणतयाच्याह्याच्याच्याविकासकाळकोरा.

Marshallese -
Nan bok jipaå ilo Kajin Majol, kallok 1-800-370-4526 ilo ejjelok wónán.

Micronesian- Pohnpeyan -
Ohng palien sawas en soum kawewe ni omw lokaia Ponape koahl 1-800-370-4526 ni sohte isais.

Mon-Khmer -
ប្រព័្ន្ធ្បមលខ្មែរ តារាសម្រាប់ ប្រព័្ន្ធ្បមលខ្មែរ 1-800-370-4526 ដើម្បីការជូនទៅនឹង

Navajo -
T'áá shi shaaza ke'ehjí bee shiká a'doowol nínzíngo Diné ke'ehjí koji t'áá jík'e hólne' 1-800-370-4526

Nepali -
(नेपाली) मा निशिक्षक भाषा सहायता पाउनका लागि 1-800-370-4526 मा फोन गर्नुहोस्।

Nilotic-Dinka -
Tén kuony ë thok ë Thuonján col 1-800-370-4526 keçin ayoc.

Norwegian -
For språkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt.

Panjabi -
ਪੰਜਾਬੀ ਲਈ ਉਪਰ ਸੰਬੰਧਿਤ ਤਰੁਣ ਸੰਖਿਆ, 1-800-370-4526 ਉੱਤੇ ਮੁਹੂਰ ਵਰਤੋਂ ਵਧੋ।

Pennsylvania Dutch -
Für Helfe in Deitsch, ruf 1-800-370-4526 aa. Es Aaruf koschtet nix.

Persian -
پریا راهنمایی به زبان فارسی با شماره 1-800-370-4526 بدون هزینه آم تحصیل کنید. انگلیسی

Polish -
Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-370-4526.