## 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 deductible?</td>
<td>$250 individual / $375 parent/child(ren)/ $500 husband and wife, employee and partner, family – In-network $500 individual / $1,000 parent/child(ren)/ $1,000 husband and wife, employee and partner, family – Out-of-network The deductible does not apply to preventive services. Coinsurance amounts do not apply toward the deductible.</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>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive services, office visits, emergency room services, urgent care, outpatient mental health, outpatient substance abuse, and rehabilitation services &amp; FDA authorized COVID-19 diagnostic tests</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 deductibles 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 out-of-pocket limit for this plan?</td>
<td>$1,000 individual / $1,500 parent/child(ren)/ $2,000 husband and wife, family (excludes deductible) – In-network out-of-pocket maximum limit up to a total out-of-pocket of $7,150 individual/$14,300 family. $2,000 individual / $4,000 parent/child(ren)/ $4,000 husband and wife, employee and partner, family – Out-of-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>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billed charges, prescription drug expenses 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 network provider?</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 referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without permission from this plan.</td>
</tr>
</tbody>
</table>
### Common Medical Event

<table>
<thead>
<tr>
<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></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>Network Provider (You will pay the least): $10 copay/visit</td>
<td>Out-of-Network Provider (You will pay the most): 30% coinsurance</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>$20 copay/visit</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>No Charge for preventive services</td>
<td>30% coinsurance for preventive services</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic test (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>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% coinsurance 30% coinsurance</td>
<td>Requires pre-approval by the plan.</td>
</tr>
</tbody>
</table>

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**Questions:** Call HR Services at (814) 865-1473 or visit us at http://ohr.psu.edu/benefits.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
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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>Tier 1- Typically Generic drugs</td>
<td>Retail- 50% coinsurance Mail- 20% coinsurance Preventive - 10% coinsurance</td>
<td>Not covered</td>
<td>Retail covers up to a 31 day supply Mail (including University Health Services pharmacy) covers up to a 90 day supply Prescription coinsurance amounts paid are not included in the deductible. Prescription-only Maximum Out-of-Pocket of $1,000 individual/ $6,000 family. Dispense as written penalties apply when the member request no substitution. Medications on Preventive Drug List, pay only the applicable coinsurance. The preventive Drug listing can be found on Penn State Open enrollment website.</td>
</tr>
<tr>
<td>Tier 2- Typically Preferred brand drugs</td>
<td>Retail- 50% coinsurance Mail- 20% coinsurance Preventive - 20% coinsurance</td>
<td>Not covered</td>
<td>Retail covers up to a 31 day supply Mail (including University Health Services pharmacy) covers up to a 90 day supply Prescription coinsurance amounts paid are not included in the deductible. Prescription-only Maximum Out-of-Pocket of $1,000 individual/ $6,000 family. Dispense as written penalties apply when the member request no substitution. Medications on Preventive Drug List, pay only the applicable coinsurance. The preventive Drug listing can be found on Penn State Open enrollment website.</td>
</tr>
<tr>
<td>Tier 3- Typically Non-preferred brand drugs</td>
<td>Retail- 70% coinsurance Mail- 70% coinsurance Preventive - 40% coinsurance</td>
<td>Not covered</td>
<td>Retail covers up to a 31 day supply Mail (including University Health Services pharmacy) covers up to a 90 day supply Prescription coinsurance amounts paid are not included in the deductible. Prescription-only Maximum Out-of-Pocket of $1,000 individual/ $6,000 family. Dispense as written penalties apply when the member request no substitution. Medications on Preventive Drug List, pay only the applicable coinsurance. The preventive Drug listing can be found on Penn State Open enrollment website.</td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>Preferred- 50% coinsurance with a $50 maximum Non-Preferred- 70% coinsurance with a $100 maximum</td>
<td>Not covered</td>
<td>Specialty drugs must be purchased through CVS Caremark Specialty Pharmacy. Maximum allowed per prescription is 31 days. Prescription coinsurance amounts paid are not included in the deductible. Prescription-only Maximum Out-of-Pocket of $1,000 individual/ $6,000 family. Dispense as written penalties apply when the member request no substitution.</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).
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>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></td>
<td></td>
<td></td>
<td></td>
<td>Medications on Preventive Drug List, (PDL) pays only the applicable coinsurance. The PDL can be found on Penn State Open enrollment website.</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>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$100 copay/visit</td>
<td>$100 copay/visit</td>
<td>Copayment waived if admitted as an inpatient. No member cost share for in or out of network FDA-authorized COVID-19 diagnostic tests. No member cost share for emergency room visits in and out of network that result in an order for or the administration of a diagnostic COVID-19 test.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$20 copay/visit</td>
<td>30% coinsurance</td>
<td>No member cost share for in or out of network FDA-authorized COVID-19 diagnostic tests. No member cost share for urgent care visits in and out of network that result in an order for or the administration of a diagnostic COVID-19 test.</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>
<td>May require pre-approval by the plan.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>May require pre-approval by the plan.</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>$10 copay/visit</td>
<td>30% coinsurance</td>
<td>May require pre-approval by the plan.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>$20 copay/visit</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</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 Plan (Technical Services)**

**Coverage Period:** 01/01/2021 – 12/31/2021

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

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#### If you need help recovering or have other special health needs

<table>
<thead>
<tr>
<th>Service</th>
<th>In-network Copay</th>
<th>Out-of-network Copay</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Home health care</strong></td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>May require pre-approval by the plan. Combined in-network and out-of-network: 120 visits per calendar year.</td>
</tr>
<tr>
<td><strong>Rehabilitation services</strong></td>
<td>$20 copay/visit</td>
<td>30% coinsurance</td>
<td>May require pre-approval by the plan. 24 visit maximum for speech therapy visits in a calendar year.</td>
</tr>
<tr>
<td><strong>Habilitation services</strong></td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>May require pre-approval by the plan. Combined in-network and out-of-network: 120 visits per calendar year.</td>
</tr>
<tr>
<td><strong>Skilled nursing care</strong></td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>May require pre-approval by the plan. Combined in-network and out-of-network: 120 visits per calendar year.</td>
</tr>
<tr>
<td><strong>Durable medical equipment</strong></td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>May require pre-approval by the plan. Combined in-network and out-of-network: $300 maximum for wigs (cancer diagnosis only) per lifetime.</td>
</tr>
<tr>
<td><strong>Hospice services</strong></td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>May require pre-approval by the plan.</td>
</tr>
</tbody>
</table>

#### If your child needs dental or eye care

<table>
<thead>
<tr>
<th>Service</th>
<th>In-network</th>
<th>Out-of-network</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Children's eye exam</strong></td>
<td>Not covered</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td><strong>Children's glasses</strong></td>
<td>Not covered</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td><strong>Children's dental check-up</strong></td>
<td>Not covered</td>
<td>Not covered</td>
<td></td>
</tr>
</tbody>
</table>

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**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

- **Other Covered Services** (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)
  - Bariatric Surgery (requires pre-approval)
  - Hearing aids
  - Non-emergency care when traveling outside of the U.S. (subject to deductible/coinsurance and balance billing)
  - Chiropractic Care
  - Infertility treatment (requires pre-approval)
  - Private-duty nursing
  - Coverage provided outside the United States

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**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 Plan (Technical Services)

Coverage Period: 01/01/2021 – 12/31/2021

Coverage for: Individual & Family | Plan Type: PPO

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 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.
- 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 Standard? 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.

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<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)</th>
<th>Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia's Simple Fracture (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ The plan’s overall deductible $250</td>
<td>▪ The plan’s overall deductible $250</td>
<td>▪ The plan’s overall deductible $250</td>
</tr>
<tr>
<td>▪ Specialist copayment $20</td>
<td>▪ Specialist copayment $20</td>
<td>▪ Specialist copayment $20</td>
</tr>
<tr>
<td>▪ Hospital (facility) coinsurance 10%</td>
<td>▪ Hospital (facility) coinsurance 10%</td>
<td>▪ Hospital (facility) coinsurance 10%</td>
</tr>
<tr>
<td>▪ Other coinsurance 10%</td>
<td>▪ Other coinsurance 10%</td>
<td>▪ Other coinsurance 10%</td>
</tr>
</tbody>
</table>

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>Deductibles</th>
<th>$250</th>
<th>Copayments</th>
<th>$20</th>
<th>Coinsurance</th>
<th>$800</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What isn’t covered</strong></td>
<td>Limits or exclusions</td>
<td>$60</td>
<td>The total Peg would pay is</td>
<td>$1,130</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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>Deductibles</th>
<th>$250</th>
<th>Copayments</th>
<th>$100</th>
<th>Coinsurance</th>
<th>$1,800</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What isn’t covered</strong></td>
<td>Limits or exclusions</td>
<td>$20</td>
<td>The total Joe would pay is</td>
<td>$2,170</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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>Deductibles</th>
<th>$250</th>
<th>Copayments</th>
<th>$200</th>
<th>Coinsurance</th>
<th>$100</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What isn’t covered</strong></td>
<td>Limits or exclusions</td>
<td>$0</td>
<td>The total Mia would pay is</td>
<td>$550</td>
<td></td>
<td></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 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, CRCoordinator@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, CRCoordinator@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 - እንቷን ከም መንግስት ከ 1-800-370-4526 ያስራ ያርካማ.
Arabic - للمساعدة في (اللغة العربية)، الرجاء الإتصال على الرقم المجاني 1-800-370-4526.
Armenian - Լրացրանք գույքից պահեստանատեր հաշվից 1-800-370-4526 չդառակում.
Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.
Bantu-Kirundi - Niba urondera urugufasha mu Kirundi, twakuse ku yi nomero 1-800-370-4526 ku busa.
Bengali-Bangala - বাংলা ভাষা সহায়তার জন্য যে নম্বর 1-800-370-4526 লেগে যেতে পারেন।
Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-370-4526 nga walay bayad.
Burmese - ပိုင်းအပ်ချင်သူအတွက် သို့ 1-800-370-4526 နှောက်ပြောပြောပါ။
Catalan - Per rebre assistència en (català), truqui al número gratuït 1-800-370-4526.
Chamorro - Para ayuda gi fino’ (Chamoru), _FM 1-800-370-4526 sin gástu.
Cherokee - ႪᏄᏲᏰᎦ ႩᏬᏲᏅᏯ ႬᏩᏭᏲᏯᏲ ႯᏱᏲᏲᏭ 1-800-370-4526 ႯᏱ ቆ AᏲᏯᎦ dᏵGᎦᏲ hᏪᏲθ.
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 chil paya hinla 1-800-370-4526.
Cushite - Gargaarsa afana Oromiffa hikkusu argachuru lakkokkofsa bibilaa 1-800-370-4526 irratti bilisan 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 - Poj jwenn asistans nan lang Kreyol 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 સહાય માટે કોઈ પણ સાધન પસં 1-800-370-4526 પર કોણ કરો.
Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i‘i, e kahea aku i ka helu kelepona 1-800-370-4526. Kāki ‘ole ‘ia 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 lu Hmoob lu davb tau rau 1-800-370-4526.
Ibo - Maka enyemaka aṣụṣu na Igbo kpọọ 1-800-370-4526 na akwụghị ụgwọ ọ buịa
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 - ကြည့်ရှုမှု ဖော်ပြချက်တွင် သို့မဟုတ် 1-800-370-4526 ဖြင့် အောက်ပါ အချက် ကို ဖော်ပြမည်။
Korean - 한국어로 연어 지원을 받고 싶으시면 무료 통화번호인 1-800-370-4526번으로 전화해 주십시오.
Kru-Bassa - 'Be'm ké gbo-ka-pá-dyé pidyi dë 'BasoÓ-wuqiuin wë, dë 1-800-370-4526
Kurdish - بەرای رەھامییی بە ئێستایە لە فەرەوەی بە شمارە 26-370-1-800-370-4526 بە خۆرەیەکەیی بەکەیەن.
Laotian - ບ້າວ້າ ທ່ອງພາບພະລູກພຽງຈັກທັງໝັດ ຈາກພະແນກພະສາລາຂາ, ຢາລືບ ວານເຈຕາ 1-800-370-4526 ທ່ອງພາບພະລູກພຽງຈັກທັງໝັດ.
Marathi - तीलभाषा (मराठी) सहायता 1-800-370-4526 केरळाकरकोणात्यांकाशविधानकारकांना.
Marshallese - Ñan bok jipaå ilo Kajin Majol, kallok 1-800-370-4526 ilo ejjelok wônân.
Micronesian-Pohnpeyan - Ohng palien sawas en soum kawewe ni owm lokaia Ponape koahl 1-800-370-4526 ni sohte isais.
Mon-Khmer - ពិសេសប្តូជាតិសាធារណៈ សហរដ្ឋអាមេរិក 1-800-370-4526 អេក្រង់ការណ៍ជួយត្រូវ។
Navajo - T’aá shiizaad k’ehjí bee shiká a’dowol nínízígo Diné k’ehjí kojí t’aá jíífe hólne 1-800-370-4526
Nepali - (नेपाली) मा निश्चित भाषा सहायता पाउनका लागि 1-800-370-4526 मा फोन गर्नुहोस्।
Nilotic-Dinka - Tën kuony ò thok ò Thuonjän col 1-800-370-4526 kecín ayóc.
Norwegian - For språkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt.
Punjabi - ਪੰਜਾਬੀ ਦੀਪ ਉਪਮਾਤਾ ਮਹਤਿਆਂ ਸਦਿ, 1-800-370-4526 ਉੱਤੇ ਮੁਹੂਰਤ ਚਲੋ ਵਧੋ।
Pennsylvania Dutch - Fer Hefle in Deitsch, ruf 1-800-370-4526 aa. Es Aaruf koschtet ni."x
Persian - برای راهنمایی به زبان فارسی با شماره 26-370-1-800 بدون هزینه ای تماس بگیرید. انگلیسی
Polish - 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 asistență lingvistică în română, luați telefoane 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 totogi.

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 balai ko yowitii e haala Pular noddee e oo numero doo 1-800-370-4526. Njodi woo fawaaki on.

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

Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-370-4526 nang walang bayad.

Telugu - 1-800-370-4526 (తెలుగు) (సాంప్రదాయ రాజధాని ముంబై)

Thai - 1-800-370-4526 หรือโทรไปที่

Tongan - Kapau ‘oku fiema’u hā tokoni ‘i he lea fāka-Tonga telefoni 1-800-370-4526 o ‘o ‘i’kai hā tōtōngi.

Trukosio - Ren aninansin chiakú ren (Kapasen Chuaub) kopwe kēkkēři 1-800-370-4526 nge esapw kamé ngonuk.

Dil çağırış il yardım için. Hiçbir ücret odemeden 1-800-370-4526.

Требуется помощь переводчика украинскому языку, позвоните по бесплатному номеру 1-800-370-4526.

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

Furr šproč hrila an’ Aziši ho-ft 1-800-370-4526, fay 1-800-370-4526 lai san owó kankan râra.

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