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/ or call 814-865-1473 to request a copy.

### Important Questions

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
</table>
| What is the overall **deductible**?            | $1,600 individual/$3,200 family – In-network  
$3,200 individual/$6,400 family – Out-of-network | 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.  
The deductible does not apply to preventive services. Coinsurance amounts do not apply toward the deductible. |
| Are there services covered before you meet your **deductible**? | Yes. Preventive services and FDA authorized COVID-19 diagnostic tests.                        | This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. |
| Are there other **deductibles** for specific services? | No.                                                                                         | 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. |
| What is the **out-of-pocket limit** for this plan? | $3,575 individual/$7,150 family – In-network  
$7,150 individual/$14,300 family – Out-of-network | 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. |
| What is not included in the **out-of-pocket limit**? | Premiums, balance-billed charges, and health care this plan does not cover do not apply to your total out of pocket limit. | 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. For a list of in-network providers, visit Aetna’s DocFind at http://ohr.psu.edu/benefits or the public DocFind at www.aetna.com. You can also call the Penn State Aetna Concierge Team at 1-855-878-4197. | 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. |
| Do you need a **referral** to see a specialist? | No.                                                                                         | You can see the specialist you choose without permission from this plan. |

**Coverage Period:** 01/01/2022 – 12/31/2022  
**Coverage for:** Individual & Family  
**Plan Type:** HDHP

**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay For Covered Services  
The Pennsylvania State University: PPO Savings

Questions: Call HR Services at (814) 865-1473 or visit us at 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: 01/01/2021 – 12/31/2021

**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>Network Provider (You will pay the least) 10% coinsurance</td>
<td>Out-of-Network Provider (You will pay the most) 30% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No member cost share for in or out of network FDA-authorized COVID-19 diagnostic tests. No member cost share for in and out of network health care provider visits that result in an order for or the administration of a diagnostic COVID-19 test.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Charge for preventive services</td>
<td>30% coinsurance for preventive services</td>
</tr>
<tr>
<td></td>
<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>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Tier 1- Typically Generic drugs</td>
<td>Retail- 10% coinsurance Mail- 10% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

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

**The Pennsylvania State University: PPO Savings**

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

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

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

<table>
<thead>
<tr>
<th>Tier 2- Typically Preferred brand drugs</th>
<th>Retail- 20% coinsurance</th>
<th>Mail- 20% coinsurance</th>
<th>Not covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 3- Typically Non-preferred brand drugs</td>
<td>Retail- 40% coinsurance</td>
<td>Mail- 40% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>Preferred- 20% coinsurance with a $65 minimum</td>
<td>Non-Preferred- 40% coinsurance with a $100 minimum</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

**Specialty drugs**

Specialty drugs must be purchased through [CVS Caremark Specialty Pharmacy](https://www.cvs.com). Maximum allowed per prescription is 31 days. Prescription coinsurance amounts paid are included in the deductible. Dispense as written penalties apply when the member requests no substitution.

<table>
<thead>
<tr>
<th>If you have outpatient surgery</th>
<th>Facility fee (e.g., ambulatory surgery center)</th>
<th>10% coinsurance</th>
<th>30% coinsurance</th>
<th>none</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>none</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If you need immediate medical attention</th>
<th>Emergency room care</th>
<th>10% coinsurance</th>
<th>10% coinsurance</th>
<th>none</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>none</td>
</tr>
</tbody>
</table>

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 included in the deductible. Dispense as written penalties apply when the member requests no substitution. Medications on Preventive Drug List, may bypass the deductible and pay only the applicable coinsurance. The preventive Drug listing can be found on Penn State Open enrollment website.

More information about prescription drug coverage is available at www.caremark.com or by calling 844-462-0203.

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<td></td>
<td>Physician/surgeon fees</td>
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<td>30% coinsurance</td>
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<td>10% coinsurance</td>
<td>30% coinsurance</td>
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**Coverage Period:** 01/01/2021 – 12/31/2021

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

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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).
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<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 have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td></td>
<td>10% coinsurance 30% coinsurance May require pre-approval by the plan.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td></td>
<td>10% coinsurance 30% coinsurance May require pre-approval by the plan.</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td></td>
<td>10% coinsurance 30% coinsurance May require pre-approval by the plan.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td></td>
<td>10% coinsurance 30% coinsurance</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td></td>
<td>10% coinsurance 30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td></td>
<td>10% coinsurance 30% coinsurance May require pre-approval by the plan.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td></td>
<td>10% coinsurance 30% coinsurance</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Home health care</td>
<td></td>
<td>10% coinsurance 30% coinsurance May require pre-approval by the plan. Combined in-network and out-of-network: 120 visits per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td></td>
<td>10% coinsurance 30% coinsurance May require pre-approval by the plan. 24 visit maximum for speech therapy visits in a calendar year.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td></td>
<td>Not Covered Not Covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td></td>
<td>10% coinsurance 30% coinsurance May require pre-approval by the plan. Combined in-network and out-of-network: 100 days per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td></td>
<td>10% coinsurance 30% coinsurance May require pre-approval by the plan. Combined network and out-of-network: $300 maximum for wigs (cancer diagnosis only) per lifetime.</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td></td>
<td>10% coinsurance 30% coinsurance May require pre-approval by the plan.</td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td>Children’s eye exam</td>
<td></td>
<td>Not covered Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td></td>
<td>Not covered Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td></td>
<td>Not covered Not covered</td>
</tr>
</tbody>
</table>

Questions: Call HR Services at (814) 865-1473 or visit us at 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: 01/01/2021 – 12/31/2021
Coverage for: Individual & Family | Plan Type: HDHP

Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acupuncture</td>
<td>• Habilitation Services</td>
</tr>
<tr>
<td>• Cosmetic Surgery</td>
<td>• Routine foot care</td>
</tr>
<tr>
<td>• Cosmetic Surgery</td>
<td>• Long-term care</td>
</tr>
<tr>
<td>• Cosmetic Surgery</td>
<td>• Weight loss programs</td>
</tr>
<tr>
<td>• Bariatric Surgery (requires pre-approval)</td>
<td>• Hearing aids</td>
</tr>
<tr>
<td>• Chiropractic Care</td>
<td>• Infertility treatment (requires pre-approval)</td>
</tr>
<tr>
<td>• Coverage provided outside the United States</td>
<td>Non-emergency care when traveling outside of the U.S. (subject to deductible/coinsurance and balance billing)</td>
</tr>
</tbody>
</table>

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.
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** $12,700

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>$1,100</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions $60
- The total Peg would pay is $2,760

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

**What isn’t covered**

- Limits or exclusions $20
- The total Joe would pay is $2,220

### 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** $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>$1,600</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$80</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions $0
- The total Mia would pay is $1,680

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/HNO 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:** ከአማርኛ እስከ እንሆ ከ 1-800-370-4526 ልም ይሏል.

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

**Armenian:** Ազգային համարով կարող եք համաձայնել 1-800-370-4526 թել":

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

**Bantu-Kirundi:** Niba urandana urugufasha mu Kirundi, twakure kini iyi nomero 1-800-370-4526 ku busa.

**Bengali-Bangala:** বাংলার ভাষা সহযোগিতার জন্য বিনিয়োগ 1-800-370-4526-এ কল করুন।

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

**Burmese:** အချင်းချင်း (အချင်းချင်း) 1-800-370-4526 အများအားဖြင့်

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

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

**Cherokee:** ᎬᏠᏏᎫᏤᏲ ᎣᎦᏫᏫᏲ ᏫᏫᏫᏲ ᎦᏨᏯ (GWW) ᏫᎣᎫᏲS 1-800-370-4526 ᎣᏩT ᏫᏫᏫᏲ JEGPA IHRO.

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

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

**Cushite:** Gargaarsa afaan Oromiffa hikuur argaachuuff kakokkoosaa bibilaa 1-800-370-4526 irratti bulisaan bibilaa.

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

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

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

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

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

**Gujarati:** ગુજરાતીમાં સાહિત્યના સહયોગ માટે કોઈ પણ અર્થની વસત 1-800-370-4526 પર કોણ કરી.
No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-800-370-4526. Kāki ‘ole ‘ia keia kōkua nei.

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

Yog xav tau kev pab txhais hxs Hmoob ntxaw taw rau 1-800-370-4526.

Maka enyemaka asusu ni Igbo kpọọ 1-800-370-4526 na akwụgwị ụgwọ ọ bulu

Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-370-4526 nga awan ti bayadanyo.

Per ricevere assistenza linguistica in italiano, puoi chiamare gratuitamente 1-800-370-4526.

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。

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

Bë’ m’è gbo-kgà-ëpp dyé pidiq dé Baso–wuqùwùn wèè, qà 1-800-370-4526

برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 به خوژایی پیامدی بکم.

Laotian - 

阮语对话语者及翻译人员可以使用1-800-370-4526。

Marathi - 

तीलभाषा (मराठी) सहायतासाठी 1-800-370-4526 कर्मांकारकोणताहीत चर्चासाठी वातावरणाच्या क्षेत्रात.

Marshallese - 

Nan bok jipa ilo Kajin Majol, kalok 1-800-370-4526 ilo ejjelok woon.

Micronesian - 

Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-370-4526 ni sohté isais.

Pohnpeyan -

Ngapki ngi bokkini ngi thama ngi bokkini 1-800-370-4526 nga ngi ngi ngi ngi ngi.

Mon-Khmer -

Ta’áa shi sha zad k’ehjii bee shik a’doowol nín’zingo Diné k’ehjii koji t’áá jíj jíj k’hólné 1-800-370-4526

Navajo -

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

Nepali -

Tèn kuony é thok é Thuonján col 1-800-370-4526 kecín ayóc.

Norwegian -

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

Panjabi -

ਪੰਜਾਬੀ ਲੜੀ ਦੁਆਰਾ ਮਾਤਰੀ ਸਥਾਿਤ ਸਰਵ, 1-800-370-4526 ਉੱਤੇ ਮੁਹੂਰਤ ਚਲ ਚੱਲੇ।

Pennsylvania Dutch -

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

Persian -

برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 بدون هیچ هزینه آم 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, vă puteți contacta pe 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 totoji.

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

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

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

Ukhitaji 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.

1-800-370-4526 งด ชาร์ท ไม่เสียค่า (สิทธิ์กิจ)

สำหรับความช่วยเหลือทางภาษาในภาษาไทย โทร 1-800-370-4526 หรือไม่เสียค่า

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

Ren animmisin chialkú ren (Kapasen Chauk) koupwe kēkkērī 1-800-370-4526 nge esapw kamé ngonuk.

(Dil) çağırış dildir yardım için. Hiçbir ücret ödededen 1-800-370-4526.

Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-370-4526.

1-800-370-4526 คุ้มครอง ไม่เสียค่า.

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

1-800-370-4526 ฟรี ไม่เสียค่า.

Fún iranlọwọ nípa èdè (Yorùbá) pè 1-800-370-4526 lái san owó kankan ràra.