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>Important 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  
The deductible does not apply to preventive services. Coinsurance amounts do not apply toward the deductible. | 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. |
| 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. | Even though you pay these expenses, they don’t count toward the out-of-pocket limit.                                                                                                                                 |
| 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. |                                                                                                                                                                                                                       |
| 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.                                                                                                                                               |
### Summary of Benefits and Coverage:

**The Pennsylvania State University: PPO Savings (Technical Services)**

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

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

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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>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>10% coinsurance</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>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>10% coinsurance</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>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Charge for preventive services</td>
<td>One routine physical per calendar year. Please refer to your preventive schedule for additional information.</td>
</tr>
<tr>
<td>If you have a test</td>
<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>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. No member cost share for in or out of network FDA-authorized COVID-19 diagnostic tests.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% coinsurance</td>
<td>Requires pre-approval by the plan.</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1- Typically Generic drugs</td>
<td>Retail- 10% coinsurance Mail- 10% coinsurance</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 included in the deductible. Dispense as written penalties apply when the member request 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.</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 (Technical Services)**

| Coverage Period: 01/01/2021 – 12/31/2021 |
| Coverage for: Individual & Family | Plan Type: HDHP |

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

| Tier 2- Typically Preferred brand drugs | Retail- 20% coinsurance | Mail- 20% coinsurance | Not covered |
| Tier 3- Typically Non-preferred brand drugs | Retail- 40% coinsurance | Mail- 40% coinsurance | Not covered |
| **Specialty drugs** | Preferred- 20% coinsurance with a $65 minimum | | Not covered |
| Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 30% coinsurance | none |
| Physician/surgeon fees | 10% coinsurance | 30% coinsurance | none |
| **If you need immediate medical attention** | Emergency room care | 10% coinsurance | 10% coinsurance | none |
| Emergency medical transportation | 10% coinsurance | 10% coinsurance | none |
| Urgent care | 10% coinsurance | 30% coinsurance | none |

**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>What You Will Pay</th>
<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>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 services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

Questions: Call HR Services at (814) 865-1473 or visit us at [http://ohr.psu.edu/benefits](http://ohr.psu.edu/benefits).
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.)

<table>
<thead>
<tr>
<th>Services</th>
<th></th>
</tr>
</thead>
<tbody>
<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></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.

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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe’s Type 2 Diabetes</th>
<th>Mia’s Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9 months of in-network pre-natal care and a hospital delivery)</td>
<td>(a year of routine in-network care of a well-controlled condition)</td>
<td>(in-network emergency room visit and follow up care)</td>
</tr>
<tr>
<td>The plan’s overall deductible</td>
<td>$1600</td>
<td>The plan’s overall deductible</td>
</tr>
<tr>
<td><strong>Specialist</strong> coinsurance</td>
<td>10%</td>
<td><strong>Specialist</strong> coinsurance</td>
</tr>
<tr>
<td><strong>Hospital (facility)</strong> coinsurance</td>
<td>10%</td>
<td><strong>Hospital (facility)</strong> coinsurance</td>
</tr>
<tr>
<td><strong>Other</strong> coinsurance</td>
<td>10%</td>
<td><strong>Other</strong> coinsurance</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></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**

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**

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: $20
- 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, 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 - የተሸፋ ማሽ በ ከአማርኛ ያላጉ 1-800-370-4526 መ ይመስከር.

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

Armenian - Ընտրի՜ք գրանցման և սպասարկման համար համարակալ 1-800-370-4526 տեղեկատվություն.

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

Bantu-Kirundi - Niba urondera urugufasha mu Kirundi, twakure kuni iyi nomero 1-800-370-4526 ku busa.

Bengali-Bangala - বাংলা ভাষায় সহায়তার জন্য বিনিয়োগ 1-800-370-4526 না করলে।

Bisayan-Visayan - Alang sa pag-abag sa pinulongang sa (Binisayang Sinugboanong) tawag sa 1-800-370-4526 nga walay bayad.

Burmese - ရောက်လာပါက ကျွန်းစုံသော အခြေခံ မိမိ၏ ပြဿနာများ 1-800-370-4526 ဖြင့် ရောသနှုန်းပါ။

Catalan - Per rebre 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 - ᏩᏏᎨᏰ ᎠᎵᏰ ᎫᏱᏰ ᏳᏰᏣᏰ ᎨᏯᏰ (GWY) ᏩᏏᎩᏰ 1-800-370-4526 Օ-ՕՏ ଏମାତ JEG.RA ᤯.RO.

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 l'paya hinla 1-800-370-4526.

Cushite - Gargaarsa afaan Oromiffa hikuun argachuu ufakkokosa bilbilaa 1-800-370-4526 irratti bilisaan bilbilaa.

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 સામાન્ય માટે કોઈ પણ અસર વચ્ચે 1-800-370-4526 પર કોઈ કરો.
हिंदी में भाषा सहायता के लिए, 1-800-370-4526 पर मुफ्त कॉल करें।

Hindi -

Yog xav tao kev pab txhais hau Hmoob hau dawb tau rau 1-800-370-4526.

Hmong -

Maka enyemaka ašuŋ su Igbo kpoŋ 1-800-370-4526 na akwu̍gũ̍ yugwo̍ o bula

Ibo -

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

Ilocano -

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。

Japanese -

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

Italian -

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

Korean -

'Βε'm'ke gbo-kgpá-kgpá dyé pídii dê Basoô'-wuçuûn weé, dâ 1-800-370-4526

Kru-Bassa -

برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 تماس بگیرید.

Kurdish -

Nan bók jipaà ilo Kajin Majol, kallok 1-800-370-4526 ilo ejjlokk wòñann.

Marshallese -

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

Micronesian-

ပြောင်မြောက်စိတ်ကျလည်ကင်း ကြည့်ပြီးနောက်ပိုမိုများ 1-800-370-4526 နည်းလမ်းကိုချိတ်ပို့ပေးပါမည်။

Mon-Khmer, Pohnpeyan -

T'áá shi shaizad k'ehjí bee shiká a'doowol ninfingo Diné k'ehjí kojí t'áá jík'e hólné' 1-800-370-4526

Navajo -

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

Nepali -

Tén kuony ê thok ê Thuonján col 1-800-370-4526 kecín ayoç.

Nilotic-Dinka -

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

Norwegian -

पंजाबी दिनी उपरामी महत सहज, 1-800-370-4526 ’उ मुहड चार्ट चों’।

Panjabi -

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

Pennsylvania Dutch -

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

Polish -
Para obter assistência linguística em português ligue para o 1-800-370-4526 gratuitamente.

Pentru asistență lingvistică în română, vă se recomandați să vă contactați numărul gratuit 1-800-370-4526.

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-370-4526.

Mo fesoasoani tau gagana l le Gagana Samoa vala’a’u le 1-800-370-4526 e aunoa ma se totagi.

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 hebal e ko yowitii e haala Pular noddee e oo numero doo 1-800-370-4526. Njodi wu fawaki on.

Ukihitaji 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.

చివరేయ యాంత్రిక సహాయం ప్రాంతం ప్రస్తావించాలంటే, తవ నంబరు 1-800-370-4526 మీకు వ్యాపక ప్రాంతం లోని స్టాషియన్ లో పిడించవచ్చు.

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

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

Dil çağrısı dildir yardımı için. Hiçbir ücret odemeden 1-800-370-4526.

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

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miền phiđền số 1-800-370-4526.

Fün iranlıowo nipa ędè (Yorùbà) pe 1-800-370-4526 lái san owó kankan rárá.