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>
</table>
| **What is the overall deductible?** | $375 individual/$750 family – In-network  
$750 individual/$1,500 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. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive services, office visits, emergency room services, urgent care, outpatient mental health, outpatient substance abuse and rehabilitation 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?** | $1,250 individual/$2,500 family – In-network out-of-pocket limit (excludes deductible) up to a total out-of-pocket of $7,150 individual / $14,300 family.  
$2,500 individual/$5,000 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, prescription drug expenses 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](http://ohr.psu.edu/benefits) or the public DocFind at [www.aetna.com](http://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. |

**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>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$20 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 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>$30 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 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>30% coinsurance 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>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. 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>30% coinsurance</td>
<td>Requires pre-approval by the plan.</td>
</tr>
</tbody>
</table>
## Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

**The Pennsylvania State University: PPO Plan – Band 2 - $45,001 - $60,000**

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

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

### 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></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</td>
<td>Not covered</td>
</tr>
<tr>
<td>Tier 2- Typically Preferred brand drugs</td>
<td>Retail- 50% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>Tier 3- Typically Non-preferred brand drugs</td>
<td>Retail- 70% coinsurance</td>
<td>Not covered</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>
</tr>
</tbody>
</table>

### Common Medical Event

- **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.

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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).
<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 have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>Network Provider (You will pay the least)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Out-of-Network Provider (You will pay the most)</td>
<td>$2,000 individual/ $8,000 family. Dispense as written penalties apply when the member request no substitution.</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Facility fee (e.g., ambulatory surgery center)</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.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% 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>May require pre-approval by the plan.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>May require pre-approval by the plan.</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance</td>
<td>Outpatient services</td>
<td>$20 copay/visit</td>
<td>No member cost share for in or out of network FDA-authorized COVID-19 diagnostic tests.</td>
</tr>
<tr>
<td>abuse services</td>
<td>Inpatient services</td>
<td>10% coinsurance</td>
<td>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 are pregnant</td>
<td>Office visits</td>
<td>$20 copay/visit</td>
<td>May require pre-approval by the plan.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>10% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>10% coinsurance</td>
<td>May require pre-approval by the plan.</td>
</tr>
<tr>
<td></td>
<td>Home health care</td>
<td>10% coinsurance</td>
<td>May require pre-approval by the plan. Combined in-network and out-of-network: 120 visits per calendar year.</td>
</tr>
</tbody>
</table>
### Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

**The Pennsylvania State University: PPO Plan – Band 2 - $45,001 - $60,000**

**Coverage Period:** 01/01/2021 – 12/31/2021  
**Coverage for:** Individual & Family  
**Plan Type:** PPO

<table>
<thead>
<tr>
<th>If you need help recovering or have other special health needs</th>
<th>Rehabilitation services</th>
<th>$30 copay/visit</th>
<th>30% coinsurance</th>
<th>May require pre-approval by the plan. 24 visit maximum for speech therapy visits in a calendar year.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Habilitation services</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
<td>May require pre-approval by the plan. Combined in-network and out-of-network: 100 days per calendar year.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
<td>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>Hospice services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
<td>May require pre-approval by the plan.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If your child needs dental or eye care</th>
<th>Children’s eye exam</th>
<th>Not covered</th>
<th>Not covered</th>
<th>May require pre-approval by the plan.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td></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

**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 – Band 2 - $45,001 - $60,000

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/ebdra/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/ebdra/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.

Questions: Call HR Services at (814) 865-1473 or visit us at http://ohr.psu.edu/benefits.
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 $375
- Specialist copayment $30
- 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>$375</td>
</tr>
<tr>
<td>Copayments</td>
<td>$30</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$800</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$60</td>
</tr>
</tbody>
</table>

The total Peg would pay is $1,265

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

- The plan's overall deductible $375
- Specialist copayment $30
- 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>$375</td>
</tr>
<tr>
<td>Copayments</td>
<td>$200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,800</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$20</td>
</tr>
</tbody>
</table>

The total Joe would pay is $2,395

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

- The plan's overall deductible $375
- Specialist copayment $30
- 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>$375</td>
</tr>
<tr>
<td>Copayments</td>
<td>$300</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$100</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$0</td>
</tr>
</tbody>
</table>

The total Mia would pay is $775

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 1-800-370-4525.

**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 gjithë shqipe telefononi falas në 1-800-370-4526.
Amharic - እንኳን እውነትን እስገንድ 1-800-370-4526 ያለ ይወጣል
Arabic - للمساعدة في (اللغة العربية)، الراجع الإتصال على الرقم المجاني 1-800-370-4526.
Armenian - Լրացիր գումարից վճարիչների հետ (հաշվիչների) համար 1-800-370-4526 միայն գնչյա
Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.
Bantu-Kirundi - Niba uondere urugufasha mu Kirundi, twakurwe kunyi nomero 1-800-370-4526 ku busa
Bengali-Bangala - বাংলার ভাষায় সহায়তার জন্য বলিয়া যে 1-800-370-4526 যে করুন।
Bisayan-Visayan - Alang sa pag-abag sa pinulongang sa (Binisayang Sinugboanon) tawag sa 1-800-370-4526 nga walay bayad.
Burmese - မြန်မာစိုးမှတ်ကျောင်းသား 1-800-370-4526 ကို သိပ်ပါကြည့်
Catalan - Per rebre assistència en (català), truqui al número gratuït 1-800-370-4526.
Chamorro - Para ayuda gi fino’ (Chamoru), åsgang 1-800-370-4526 sin gástu.
Cherokee - ᎨᏏᎨᏳ ᎣᎳᎩ ᎨᏏᏲᏨᏳ ᏭᎦᏭᏳ ᏤᏤᏨᏳ ᏤᏩᏳ 1-800-370-4526 ᏤᏩ Ᏻ ᎨᏳᏆ ᎨᏥ ᎨᏳᏨ ᎨᏥ Ᏻ.Threading.
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 - Garaa xaa xaan Oromiffa hikkuu aragchuun lakkokkofsa bibilaa 1-800-370-4526 irratti bilisaan 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 jwev assistans 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 - જુઝાતીયા લાઈનમાં સહાય માટે કોઈ પણ પરિસ્થિતિ વગર 1-800-370-4526 પર કોટી કરો.
Para obter assistência linguística em português ligue para o 1-800-370-4526 gratuitamente.

Pentru asistență lingvistică în română, atunci la numărul gratuit 1-800-370-4526.

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

Mo fesoasoani tae gaga Gana Samoa vala’au le 1-800-370-4526 e aunoa ma se totogi.

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 hebu balai e ko yowitii e haala Pular nodde e oo numero doo 1-800-370-4526. Njodi wuu fawaaki 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.

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

Kapau 'oku fia'ma'ta hā tokom i'i he lea faka-Tonga telefon' 1-800-370-4526 o'o 'ikai hā tōtōngi.

Ren anininisin chiakú ren (Kapasen Chuuk) kopwe kēkkēērī 1-800-370-4526 nge esapw kamé ngonuk.

Turkish -
(Dil) çağırış dil yardım için. Hiçbir ücret odemeden 1-800-370-4526.

Ukrainian -
Щоб отримати допомогу переводача української мови, зв'яжіться за безкоштовним номером 1-800-370-4526.

Urdu -
ا ریکار کے ٹی وی سی میں ریڈیو 1-800-370-4526 ای ٹی وی سی کی نجی خوشی پر ہے نجی خوشی پر ہے

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

Yiddish -
א מערער היכל דה ווייטט (Yoruba) מ 1-800-370-4526 לאי סן און קאנקן ראה.

Yoruba -
Fún iránluwo nípa èdè (Yorùbá) pé 1-800-370-4526 làyi sọn owó kankan nárá.