The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows 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.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$375 individual/$750 family – In-network&lt;br&gt;$750 individual/$1,500 family – Out-of-network&lt;br&gt;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.</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>$1,250 individual/$2,500 family – In-network&lt;br&gt;out-of-pocket limit (excludes deductible) up to a total out-of-pocket of $7,150 individual / $14,300 family.&lt;br&gt;$2,500 individual/$5,000 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>

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 Plan – Band 2 - $45,001 - $60,000**

**Coverage Period:** 01/01/2020 – 12/31/2020

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

---

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>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)</td>
<td>30% coinsurance (X-Ray)</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>

---

**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

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Coverage Period: 01/01/2020 – 12/31/2020

Coverage for: Individual & Family | Plan Type: PPO

<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</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1- Typically Generic drugs</td>
<td>Retail- 50% coinsurance Mail- 20% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at <a href="http://www.caremark.com">www.caremark.com</a> or by calling 844-462-0203</td>
<td>Tier 2- Typically Preferred brand drugs</td>
<td>Retail- 50% coinsurance Mail- 20% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Tier 3- Typically Non-preferred brand drugs</td>
<td>Retail- 70% coinsurance Mail- 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></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.
| Common Medical Event | Services You May Need | | | | Limitations, Exceptions, & Other Important Information |
|---------------------|----------------------|-------------------------------|-----------------|
|                     |                      | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 30% coinsurance |
| If you need immediate medical attention | Physician/surgeon fees | 10% coinsurance | 30% coinsurance |
| If you need immediate medical attention | Emergency room care | $100 copay/visit | $100 copay/visit |
| If you need immediate medical attention | Emergency medical transportation | 10% coinsurance | 10% coinsurance |
| If you need immediate medical attention | Urgent care | $30 copay/visit | 30% coinsurance |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 10% coinsurance | 30% coinsurance |
| If you have a hospital stay | Physician/surgeon fees | 10% coinsurance | 30% coinsurance |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | $20 copay/visit | 30% coinsurance |
| If you need mental health, behavioral health, or substance abuse services | Inpatient services | 10% coinsurance | 30% coinsurance |
| If you are pregnant | Office visits | $20 copay/visit | 30% coinsurance |
| If you are pregnant | Childbirth/delivery professional services | 10% coinsurance | 30% coinsurance |
| If you are pregnant | Childbirth/delivery facility services | 10% coinsurance | 30% coinsurance |
| If you are pregnant | Home health care | 10% coinsurance | 30% coinsurance |

$2,000 individual/ $8,000 family. Dispense as written penalties apply when the member request no substitution.

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.

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.

May require pre-approval by the plan.
### 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:** 01/01/2020 – 12/31/2020  
**Coverage for:** Individual & Family  
**Plan Type:** PPO

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

<table>
<thead>
<tr>
<th>Service</th>
<th>Copay/Visit</th>
<th>Coinsurance</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehabilitation services</td>
<td>$30</td>
<td>30%</td>
<td>May require pre-approval by the plan. 24 visit maximum for speech therapy visits in a calendar year.</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>10%</td>
<td>30%</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%</td>
<td>30%</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%</td>
<td>30%</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>Copay/Visit</th>
<th>Coinsurance</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children's eye exam</td>
<td>Not covered</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Children's glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<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:**
- Acupuncture
- Cosmetic Surgery
- Routine foot care
- 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
- Infertility treatment (requires pre-approval)
- Non-emergency care when traveling outside of the U.S. (subject to deductible/coinsurance and balance billing)
- Private-duty nursing
- Coverage provided outside the United States

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

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

Your Grievance and Appeals Rights:

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

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.
About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

---

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible**: $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**: $12,600

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

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$375</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$875</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What isn't covered</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limits or exclusions</td>
<td>$100</td>
</tr>
</tbody>
</table>

**The total Peg would pay is**: $1,350

---

### 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**: $7,000

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

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</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>$200</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What isn't covered</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limits or exclusions</td>
<td>$4,300</td>
</tr>
</tbody>
</table>

**The total Joe would pay is**: $5,075

---

### 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**: $1,800

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

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</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>$100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What isn't covered</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limits or exclusions</td>
<td>$100</td>
</tr>
</tbody>
</table>

**The total Mia would pay is**: $675

---

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 gjihën shqipe telefononi falas në 1-800-370-4526.
Amharic - እንገድ እንገድ እሳንወተ ያለ 1-800-370-4526 ማስ መርጋ እያፋ ከምርጋ መርጋ ያለ 1-800-370-4526 ማስ መርጋ ከምርጋ.
Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-370-4526.
Armenian - Լծածք գնելքցքներ ուղղացրեք (հարցման) քվաղ 1-800-370-4526 ունիթան գնում;
Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.
Bantu-Kirundi - Niba urondera urugufasha mu Kirundi, twakwwe kun yi noremo 1-800-370-4526 ku busa.
Bengali-Bangla - বাংলা ভাষা সহায়তার জন্য বিনিয়োগ, 1-800-370-4526 তা কর্ন করুন।
Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-370-4526 nga walay bayad.
Burmese - အပြင်ပြောဆိုများစွာ အပြည့်အစား 1-800-370-4526 နှင့် တက်ပါ။
Catalan - Per rebrer assistència en (català), truqui al número gratuït 1-800-370-4526.
Chamorro - Para ayuda gi fino’ (Chamoru), ågang 1-800-370-4526 sin gástu.
Cherokee - ᎨᏭᎩᏯᏰ ᎭᎲᏰ ᏯᏭᎲᏱ ᎰᏭᎲᏯᏗᏯ ᎬᏩᏯ (ᏯᎲᎩ) ᏭᏲᎲᏯᏲᏲ 1-800-370-4526 Ꮹ-ᏭᏱ ᏭᏰ ᏳᎯᏲᏲ ᏭᏰ ᏳᎾᏲ ᏭᏲᎩ.
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 hikkuu argachuu lakkokkofsa bilbila 1-800-370-4526 irrrati bilissan bilbila.
Dutch - Bel voor tolk- en vertaal diensten 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 jwen ay asistans nan lang Kreyl 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 લાભ માટે કોઈ પણ પ્રશ્ન પાણે 1-800-370-4526 પર કોણ કરો.
Hawaiian -
No ke kōkua ma ka ‘ōlelo Hawai‘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 dawb tau rau 1-800-370-4526.

Ibo -
Maka enyemaka asụsụ na Igbo kpoọ 1-800-370-4526 na akwụghị ụgwọ ọ bula

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。

Kare -
Kare ar slu. Jëfandikuk ko bëggëf 1-800-370-4526 33333333333333333333

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

Kru-Bassa -
'Bëm'ke gbo-kpá-kpá dyé pidyi dé Baso-wuqůin wë, dà 1-800-370-4526

Kurdish -
برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 به خواستاری پیامدی بکن.

Laotian -
Naugh moobtom kokma ooy bui muamhaph reducing, na gabout lai 1-800-370-4526 diayay seng ka la.

Marathi -
तीलभाषा (मराठी) सहायता साधारण 1-800-370-4526 क्रमांकांकवरण ओहुल्हइक्चाव्हिवयकाळकरा.

Marshallese -
Nan bok jipaa ilo Kajin Major, kallok 1-800-370-4526 ilo ejjelok woon.

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

Pohnpeyan -

Mon-Khmer -

Cambodian -

Navajo -
T’áá shi shaad k’ejhi bee shiká a’doowol nñifingo Diné k’ejhi kojj t’áá jíj’ke hólne’ 1-800-370-4526

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

Niloic-Dinka -
Tén kuony é thok é Thuonjǎn col 1-800-370-4526 kećin ayọć.

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

Panjabi -
ਪੰਜਾਬੀ ਦੀਚ ਉਪਸਾ ਸਮਾਚਾਰ ਸਹਿ, 1-800-370-4526 ਉੱਥੇ ਮੁਹੂਰ ਚਲਾ ਵਾਲੇ।

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

Persian -
برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 بدون هیچ هزینه ای تماس بگیرید. انگلیسی

Polish -
Aby uzyskać pomoc w języku Polskim, zadzwonić 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, puteți apela 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 toto'i.

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 yowiti e haala Pular noddee e oo numero doo 1-800-370-4526. Njodi woo 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.

Para obter assistência em telugu, ligue para o 1-800-370-4526.

Thailand

สำหรับความช่วยเหลือทางภาษาเป็นภาษาไทย โปรดติดต่อกับ 1-800-370-4526 หรือไม่ต้องเสียค่าใช้จ่าย.

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

Ren anininsin chialkú ren (Kapase Niuhe) kopwe kēkkēəri 1-800-370-4526 nge esapw kamé ngonuk.

(Dil) çağrısı dil yardımı için. Hiçbir ücret odemeden 1-800-370-4526.

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

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

Furbur la ari la (Yoruba) pe 1-800-370-4526 lai san ówó kankan rará.