### Important Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Answers</th>
<th>Why This Matters</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>UVA Network: Individual $800 / Family $1,600. Aetna Network: Individual $800 / Family $1,600. Out-of-Network: Individual $1,600 / Family $3,200.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. In-network office visits &amp; preventive care are covered before you meet your deductible.</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. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a></td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>There are no other specific deductibles.</td>
<td>You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>UVA Network: Individual $5,500 / Family $11,000. Aetna Network: Individual $5,500 / Family $11,000. Out-of-Network: Individual $11,000 / Family $22,000.</td>
<td>The out–of–pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out–of–pocket limits until the overall family out–of–pocket limit has been met.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums, balance-billing charges, health care this plan doesn’t cover &amp; penalties for failure to obtain pre-authorization for services.</td>
<td>Even though you pay these expenses, they don’t count toward the out–of–pocket limit.</td>
</tr>
<tr>
<td><strong>Will you pay less if you use a network provider?</strong></td>
<td>Yes. See <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-800-987-9072 for a list of UVA Network providers.</td>
<td>You pay the least if you use a provider in UVA Network Provider. You pay more if you use a provider in Aetna Network Provider. 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><strong>Do you need a referral to see a specialist?</strong></td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
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>UVA Network Provider (You will pay the least)</th>
<th>Aetna Network Provider (You will pay more)</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>$25 copay/visit</td>
<td>$40 copay/visit</td>
<td>$40% coinsurance</td>
<td>Includes Internist, General Physician, Family Practitioner or Pediatrician. Coverage is limited to 26 visits for Chiropractic care and 20 visits for acupuncture per calendar year. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Age and frequency schedules may apply.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$50 copay/visit</td>
<td>$80 copay/visit</td>
<td>$40% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preventive care /screening /immunization</td>
<td>No charge, except hearing exams not covered</td>
<td>No charge, except hearing exams not covered</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>$6 copay/30 days; $14 copay/90 days</td>
<td>$6 copay/30 days; $14 copay/90 days mail order</td>
<td>$6 copay plus billed amount minus contracted rate/30 days</td>
<td>Covers up to 30-day supply (retail), 90-day supply (mail order, UVA Network, CVS pharmacies). No charge for preferred generic FDA-approved women's contraceptives in-network. Your cost will be higher for choosing Brand over Generics.</td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at <a href="http://www.aetnapharmacy.com/standard">www.aetnapharmacy.com/standard</a></td>
<td>Preferred brand drugs</td>
<td>After deductible, 20% coinsurance with $150 max/30 days, 15% coinsurance with $375 max 90 days</td>
<td>After deductible, 20% coinsurance with $34 min/$150 max/30 days, 15% coinsurance with $75 min/$375 max/90 days mail order</td>
<td>After deductible, 20% coinsurance with $34 min/$150 max plus billed amount minus contracted rate/30 days</td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>UVA Network Provider (You will pay the least)</td>
<td>Aetna Network Provider (You will pay more)</td>
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<td>Limitations, Exceptions, &amp; Other Important Information</td>
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<td>----------------------</td>
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<td>------------------------------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>After deductible, 20% coinsurance with $225 max/30 days, 15% coinsurance with $475 max/90 days</td>
<td>After deductible, 20% coinsurance with $68 min/$225 max/30 days, 15% coinsurance with $150 min/$475 max/90 days mail order</td>
<td>After deductible, 20% coinsurance with $68 min/$225 max plus billed amount minus contracted rate/30 days</td>
<td>Covers up to 30-day supply (retail), 90-day supply (mail order, UVA Network, CVS pharmacies). No charge for preferred generic FDA-approved women’s contraceptives in-network. Your cost will be higher for choosing Brand over Generics.</td>
</tr>
<tr>
<td>Specialty drugs: Generic (G), Preferred brand (P), Non-preferred brand (N)</td>
<td>After deductible, G: 20% coinsurance with $100 max; P: 20% coinsurance with $150 max; N: 20% coinsurance with $200 max</td>
<td>After deductible, G: 20% coinsurance with $100 max; P: 20% coinsurance with $150 max; N: 20% coinsurance with $200 max</td>
<td>Not covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>25% coinsurance</td>
<td>25% coinsurance</td>
<td>25% coinsurance</td>
<td>No coverage for non-emergency use.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>No coverage for non-emergency transport.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>No coverage for non-urgent use.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Pre-authorization required for out-of-network care</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office: $25 copay/visit, other outpatient services: 20% coinsurance</td>
<td>Office: $40 copay/visit, other outpatient services: 20% coinsurance</td>
<td>Office &amp; other outpatient services: 40% coinsurance</td>
<td>Pre-authorization required for out-of-network care</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>UVA Network Provider (You will pay the least)</td>
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<td>----------------------</td>
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<td>-------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge for routine services</td>
<td>No charge for routine services</td>
<td>40% coinsurance</td>
<td>Cost sharing does not apply to certain preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Pre-authorization required for out-of-network care may apply.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>90 visits/calendar year. Pre-authorization required for out-of-network care</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$40 copay/visit</td>
<td>$40 copay/visit</td>
<td>40% coinsurance</td>
<td>Coverage is limited to 40 visits per calendar year for Physical and Occupational Therapy combined, 40 visits per calendar year for Speech Therapy.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$40 copay/visit</td>
<td>$40 copay/visit</td>
<td>40% coinsurance</td>
<td>180 days/calendar year. Pre-authorization required for out-of-network care</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse. Pre-authorization required for out-of-network care</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td></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>
<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>
<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>
<td>Not covered</td>
<td>Not covered</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.)

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Adult & Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult & Child)
- Routine foot care
- Weight loss programs - Except for required preventive services.
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult & Child)
- Routine foot care
- Weight loss programs - Except for required preventive services.
- Acupuncture - 20 visits/calendar year.
- Bariatric surgery
- Chiropractic care - 26 visits/calendar year.
- Infertility treatment – Limited to the diagnosis & treatment of underlying medical condition.
- Artificial insemination, ovulation induction & advanced reproductive technology: $15,000 maximum/lifetime.

Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)

- Acupuncture - 20 visits/calendar year.
- Bariatric surgery
- Chiropractic care - 26 visits/calendar year.
- Infertility treatment – Limited to the diagnosis & treatment of underlying medical condition.
- Artificial insemination, ovulation induction & advanced reproductive technology: $15,000 maximum/lifetime.

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 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.
- 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, or by calling our general toll free number 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 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.
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:

**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 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)

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan's overall deductible</td>
<td>$800</td>
</tr>
<tr>
<td>Specialist copayment</td>
<td>$50</td>
</tr>
<tr>
<td>Hospital (facility) coinsurance</td>
<td>20%</td>
</tr>
<tr>
<td>Other coinsurance</td>
<td>20%</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**: $12,800

**Cost Sharing**
- Deductibles: $800
- Copayments: $74
- Coinsurance: $2,001

**What isn't covered**
- Limits or exclusions: $60

**The total Peg would pay is**: $2,935

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

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>The plan's overall deductible</td>
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<td>$50</td>
</tr>
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<td>20%</td>
</tr>
<tr>
<td>Other coinsurance</td>
<td>20%</td>
</tr>
</tbody>
</table>

This EXAMPLE event includes services like:
- Primary care physician office visits (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs
- Durable medical equipment (glucose meter)

**Total Example Cost**: $7,400

**Cost Sharing**
- Deductibles: $900
- Copayments: $426
- Coinsurance: $1,089

**What isn't covered**
- Limits or exclusions: $55

**The total Joe would pay is**: $2,470

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

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>The plan's overall deductible</td>
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</tr>
<tr>
<td>Specialist copayment</td>
<td>$50</td>
</tr>
<tr>
<td>Hospital (facility) coinsurance</td>
<td>20%</td>
</tr>
<tr>
<td>Other coinsurance</td>
<td>20%</td>
</tr>
</tbody>
</table>

This EXAMPLE event includes services like:
- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

**Total Example Cost**: $1,900

**Cost Sharing**
- Deductibles: $800
- Copayments: $280
- Coinsurance: $131

**What isn't covered**
- Limits or exclusions: $0

**The total Mia would pay is**: $1,391

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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 866-393-0002.

**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 unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 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.*
Hindi - हिन्दी में भाषा सहायता के लिए, 1-800-370-4526 पर मुफ्त कॉल करें।
Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-370-4526.
Ibo - Maka enyemaka asụsụ na Igbo kpọọ 1-800-370-4526 na akwughị ụgwọ ọ bụla
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。
Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-370-4526 번으로 전화해 주십시오.
Kru-Bassa - Be m'ké gbo-kpá-kpá dyé pidyi dë Básso-wuqúün wëe, dë 1-800-370-4526
Kurdish - 1-800-370-4526
Laotian - Ohng palien sawas en soun kayew ni omw lokaia Ponape koahl 1-800-370-4526 ni sohte isais.
Marathi - कोणत्याही शुल्की भाषा सेवा प्राप्त करण्यासाठी, 1-800-370-4526 वर फोन करा.
Marshallese - Ñan bök jipañ ilo Kajin Majol, kallok 1-800-370-4526 ilo ejjelok wônän.
Mon-Khmer, Cambodian - 1-800-370-4526
Navajo - T'áá shi shizaad k'ehjí bee shiká a'doowol nińzingo Diné k'ehjí koji' t'áá jiík'e hólne' 1-800-370-4526
Nepali - (नेपाली) मा नि:शुल्क भाषा सहायता उपलब्ध काली 1-800-370-4526 मा फोन गर्नुहोस्।
Nilotic-Dinka - Tën kuocny ê thok ê Thuonjân col 1-800-370-4526 kecîn ayôc.
Norwegian - For språkassistance på norsk, ring 1-800-370-4526 kostnadsfritt.
Panjabi - ਪੰਜਾਬੀ ਦੀ ਵਿਦਵਾਂ ਵਪਾਰੀ ਸਮਾਜੀ ਕਰਕੇ, 1-800-370-4526 ਉੱਤੇ ਭਾਸ਼ਾ ਵਾਲੇ ਵੋਨ।
Pennsylvania Dutch - Fer 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 آی تماس بگیرید. انگلیسی
Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-370-4526.
Portuguese - Para obter assistência linguística em português ligue para o 1-800-370-4526 gratuitamente.
Romanian - Pentru asistenţă lingvistică în românește telefonaţi la numărul gratuit 1-800-370-4526
To obtain assistance from a Russian-speaking translator, call the free number 1-800-370-4526.

For Samoan, call 1-800-370-4526 for assistance in the Samoan language.

For Serbo-Croatian, call 1-800-370-4526 for help in the Croatian language.

For Spanish, call 1-800-370-4526 for assistance in the Spanish language.

For Sudanic-Fulfude, call 1-800-370-4526 for help in the Fulfude language.

For Swahili, call 1-800-370-4526 for help in the Swahili language.

For Syriac, call 1-800-370-4526 for Syriac assistance.

For Tagalog, call 1-800-370-4526 for assistance in the Tagalog language.

For Telugu, call 1-800-370-4526 for help in the Telugu language.

For Thai, call 1-800-370-4526 for Thai assistance.

For Tongan, call 1-800-370-4526 for help in the Tongan language.

For Trukese, call 1-800-370-4526 for assistance in the Fijian language.

For Turkish, call 1-800-370-4526 for help in the Turkish language.

For Ukrainian, call 1-800-370-4526 for assistance in the Ukrainian language.

For Urdu, call 1-800-370-4526 for help in the Urdu language.

For Vietnamese, call 1-800-370-4526 for assistance in the Vietnamese language.

For Yiddish, call 1-800-370-4526 for help in the Yiddish language.

For Yoruba, call 1-800-370-4526 for help in the Yoruba language.