



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, <https://www.aetna.com/sbcsearch/getpolicydocs?u=081100-090020-012081> or by calling 1-866-529-2517. 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 1-866-529-2517 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|---|
| What is the overall <u>deductible</u>? | In- <u>network</u> : Individual \$500 / Family \$1,000. | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . |
| Are there services covered before you meet your <u>deductible</u>? | Yes. Certain office visits, <u>preventive care</u> , <u>urgent care</u> and <u>prescription drugs</u> in- <u>network</u> . | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other <u>deductibles</u> for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u>? | In- <u>network</u> : Individual \$7,800 / Family \$15,600. | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. |
| What is not included in the <u>out-of-pocket limit</u>? | <u>Premiums</u> and health care this <u>plan</u> doesn't cover. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |
| Will you pay less if you use a <u>network provider</u>? | Yes. See http://www.aetna.com/docfind or call 1-866-529-2517 for a list of in- <u>network providers</u> . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u>? | Yes. | This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> . |



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

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---|--|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$25 <u>copay</u> /visit, <u>deductible</u> does not apply | Not covered | None |
| | <u>Specialist</u> visit | \$50 <u>copay</u> /visit, <u>deductible</u> does not apply | Not covered | None |
| | <u>Preventive care /screening /immunization</u> | No charge | Not covered | You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | Lab: \$25 <u>copay</u> /visit, <u>deductible</u> does not apply; X-ray: \$60 <u>copay</u> /visit, <u>deductible</u> does not apply | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | \$300 <u>copay</u> /visit, <u>deductible</u> does not apply | Not covered | None |
| If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at http://client.formularynavigator.com/Search.aspx?siteCode=0464665371 | Preferred/non-preferred generic drugs (Tier 1) | \$15 <u>copay</u> / prescription (retail), \$30 <u>copay</u> / prescription (mail order), <u>deductible</u> does not apply | Not covered | Covers up to a 30 day supply (retail prescription), 31-90 day supply (mail order prescription). Applicable cost share plus difference (brand minus generic cost) applies for brand when generic available. No charge for preferred generic FDA-approved women's contraceptives in- <u>network</u> . |
| | Preferred brand drugs (Tier 2) | \$50 <u>copay</u> / prescription (retail), \$100 <u>copay</u> / prescription (mail order), <u>deductible</u> does not apply | Not covered | |
| | Non-preferred brand drugs (Tier 3) | \$80 <u>copay</u> / prescription (retail), \$160 <u>copay</u> / prescription (mail order), <u>deductible</u> does not apply | Not covered | |
| | Preferred/non-preferred <u>specialty drugs</u> (Tier 4) | 20% <u>coinsurance</u> up to a \$250 maximum/ prescription for up to a 30 day supply, <u>deductible</u> does not apply | Not covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|--|---|---|---|
| | | In-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) | 20% <u>coinsurance</u> for hospital facility; 10% <u>coinsurance</u> for free standing facility | Not covered | None |
| | Physician/surgeon fees | 20% <u>coinsurance</u> for hospital facility; 10% <u>coinsurance</u> for free standing facility | Not covered | None |
| If you need immediate medical attention | <u>Emergency room care</u> | \$500 <u>copay/visit</u> | \$500 <u>copay/visit</u> | <u>Copay</u> waived if admitted. No coverage for non-emergency care. |
| | <u>Emergency medical transportation</u> | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | Precertification is required for certain services. |
| | <u>Urgent care</u> | \$50 <u>copay/visit</u> , <u>deductible</u> does not apply | Not covered | No coverage for non-urgent use. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% <u>coinsurance</u> | Not covered | None |
| | Physician/surgeon fees | 20% <u>coinsurance</u> | Not covered | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Outpatient office visits: \$50 <u>copay/visit</u> , <u>deductible</u> does not apply; All other outpatient services: 10% <u>coinsurance</u> | Not covered | None |
| | Inpatient services | 20% <u>coinsurance</u> | Not covered | None |
| If you are pregnant | Office visits | No charge | Not covered | <u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 20% <u>coinsurance</u> | Not covered | |
| | Childbirth/delivery facility services | 20% <u>coinsurance</u> | Not covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|----------------------------------|--|---|--|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 20% <u>coinsurance</u> | Not covered | Coverage is limited to 100 visits per year. |
| | <u>Rehabilitation services</u> | \$25 <u>copay/visit</u> , <u>deductible</u> does not apply | Not covered | None |
| | <u>Habilitation services</u> | 10% <u>coinsurance</u> | Not covered | None |
| | <u>Skilled nursing care</u> | 20% <u>coinsurance</u> | Not covered | Coverage is limited to 100 days per benefit period. |
| | <u>Durable medical equipment</u> | 20% <u>coinsurance</u> | Not covered | Coverage is limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse. |
| | <u>Hospice services</u> | 20% <u>coinsurance</u> | Not covered | None |
| If your child needs dental or eye care | Children's eye exam | No charge | Not covered | Coverage is limited to up to age 19. |
| | Children's glasses | No charge | Not covered | Coverage is limited to 1 pair of glasses (lenses and frames) or a one-year supply of contact lenses up to age 19. |
| | Children's dental check-up | 0% <u>coinsurance</u> | Not covered | Coverage is limited to 2 prophylaxis (cleanings) and 2 fluoride applications a year up to age 19. |

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.)

- | | | |
|---|--|---|
| <ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult) • Hearing aids • Long-term care | <ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • Private-duty nursing • Routine eye care (Adult) | <ul style="list-style-type: none"> • Routine foot care • Weight loss programs |
|---|--|---|

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

- | | |
|--|---|
| <ul style="list-style-type: none"> • Acupuncture • Bariatric surgery | <ul style="list-style-type: none"> • Chiropractic care - Coverage is limited to 20 visits. • Infertility treatment - Benefit limitations may apply. |
|--|---|

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: California Department of Managed Health Care, 888-466-2219, 1-877-688-9891 (TDD), <http://www.dmhc.ca.gov>.

- For more information on your rights to continue coverage, contact the plan at 1-866-529-2517.

- 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, or by calling our general toll free number at 1-866-529-2517.
- California Department of Managed Health Care, 888-466-2219, 1-877-688-9891 (TDD), <http://www.dmhc.ca.gov>.
- 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.
- Additionally, a consumer assistance program can help you file your appeal. Contact California Consumer Assistance Program, Operated by the California Department of Managed Health Care, 980 9th Street, Suite 500, Sacramento, CA 95814-2725, 888-466-2219, 877-688-9891 (TDD), Fax: 916-255-5241, <http://www.dmhc.ca.gov>, helpline@dmhc.ca.gov

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)

- The plan's overall deductible **\$500**
- Specialist copayment **\$50**
- Hospital (facility) coinsurance **20%**
- Other coinsurance **20%**

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: | |
| <i>Cost Sharing</i> | |
| <u>Deductibles</u> | \$500 |
| <u>Copayments</u> | \$200 |
| <u>Coinsurance</u> | \$2,000 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$2,760 |

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

- The plan's overall deductible **\$500**
- Specialist copayment **\$50**
- Hospital (facility) coinsurance **20%**
- Other coinsurance **20%**

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: | |
| <i>Cost Sharing</i> | |
| <u>Deductibles</u> | \$500 |
| <u>Copayments</u> | \$1,300 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$1,820 |

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

- The plan's overall deductible **\$500**
- Specialist copayment **\$50**
- Hospital (facility) coinsurance **20%**
- Other coinsurance **20%**

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: | |
| <i>Cost Sharing</i> | |
| <u>Deductibles</u> | \$500 |
| <u>Copayments</u> | \$700 |
| <u>Coinsurance</u> | \$90 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,290 |

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-866-529-2517.

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 1-866-529-2517.

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 California and Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, ancestry, religion, sex, marital status, age, gender, gender identity, sexual orientation or disability.

Aetna provides 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 race, color, national origin, ancestry, religion, sex, marital status, age, gender, gender identity, sexual orientation or disability, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator, Non-HMO,
P.O. Box 14462, Lexington, KY 40512,
1-800-648-7817, TTY: 711, Fax: 859-425-3379,
CRCoordinator@aetna.com.

Civil Rights Coordinator, HMO,
P.O. Box 24030, Fresno, CA 93779,
1-800-648-7817, TTY: 711, Fax: 860-262-7705,
CRCoordinator@aetna.com.

You can also file a complaint with the California Department of Insurance at www.insurance.ca.gov, or at: Consumer Services Division, 300 Spring Street South Tower, Los Angeles CA 90013, or at 1-800-927-HELP (4357), TDD: 1-800-482-4TDD (4833).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights if there is a concern of discrimination based on the federal protected classes which include race, color, national origin, age, disability, or sex. You can 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 (Aetna).

- Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-866-529-2517. Kāki ‘ole ‘ia kēia kōkua nei.
- Hindi - हन्दिी में भाषा सहायता के लएि, 1-866-529-2517 पर मुफ्त कॉल करें।
- Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-866-529-2517.
- Ibo - Maka enyemaka asụsụ na Igbo kpọọ 1-866-529-2517 na akwughị ugwo ọ bụla
- Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-866-529-2517 nga awan ti bayadanyo.
- Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-866-529-2517.
- Japanese - 日本語で援助をご希望の方は、1-866-529-2517 まで無料でお電話ください。
- Karen - လာတၢ်မၤစၢလၢတၢ်ကတိၤကိၣ်အဂီၢ် ကိၣ် ဂိး 1-866-529-2517 လၢတအိၣ်ဒီးတၢ်လၢတၢ်ညၢနလၢတၢ်စၢလၢ
- Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-866-529-2517 번으로 전화해 주십시오.
- Kru-Bassa - Be´m`ké gbo-kpá-kpá dyé pídyi dé Bašwó`wuḍuñ wεε, dá 1-866-529-2517
- Kurdish - برای راهنمایی به زبان فارسی با شماره 1-866-529-2517 به خۆرای پهیوهندی بکهن.
- Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-866-529-2517 ໂດຍບໍ່ເສຍຄ່າໂທ.
- Marathi - कोणत्याही शुल्काशुवाय भाषा सेवा प्राप्त करण्यासाठी, 1-866-529-2517 वर फोन करा.
- Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-866-529-2517 ilo ejjelok wōnān.
- Micronesian - Pohnpeyan Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-866-529-2517 ni sohte isais.
- Mon-Khmer, Cambodian - សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-866-529-2517 ដោយឥតគិតថ្លៃ។
- Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-866-529-2517
- Nepali - (नेपाली) मा नःशुल्क भाषा सहायता पाउनका लागि 1-866-529-2517 मा फोन गर्नुहोस् ।
- Nilotic-Dinka - Tèn kuwoony ë thok ë Thuonjäng col 1-866-529-2517 kecïn ayöc.
- Norwegian - For språkassistanse på norsk, ring 1-866-529-2517 kostnadsfritt.
- Panjabi - ਪੰਜਾਬੀ ਵੱਚੋਂ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-866-529-2517 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
- Pennsylvania Dutch - Fer Hilfe in Deitsch, ruf: 1-866-529-2517 aa. Es Aaruf koschtet nix.

- Persian - برای راهنمایی به زبان فارسی با شماره 1-866-529-2517 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
- Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-866-529-2517.
- Portuguese - Para obter assistência linguística em português ligue para o 1-866-529-2517 gratuitamente.
- Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-866-529-2517
- Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-866-529-2517.
- Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-866-529-2517 e aunoa ma se totogi.
- Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-866-529-2517.
- Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-866-529-2517.
- Sudanic-Fulfude - Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-866-529-2517 Njodi woo fawaaki on.
- Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-866-529-2517 bila malipo.
- Syriac - ܠܗܘܢܐ ܩܘܪܝܢܐ ܠܗܘܢܐ ܩܘܪܝܢܐ ܠܗܘܢܐ ܩܘܪܝܢܐ ܠܗܘܢܐ ܩܘܪܝܢܐ ܠܗܘܢܐ ܩܘܪܝܢܐ 1-866-529-2517 ܩܘܪܝܢܐ.
- Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-866-529-2517 nang walang bayad.
- Telugu - భూషణి సాయం కోరకు ఎలాంటి ఖరీచు లేకుండా 1-866-529-2517 కు శ్రీ చేయండి. (తెలుగు)
- Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-866-529-2517 ฟรีไม่มีค่าใช้จ่าย
- Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-866-529-2517 'o 'ikai hā tōtōngi.
- Trukese - Ren ánninisn chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-866-529-2517 nge esapw kamé ngonuk.
- Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemedi 1-866-529-2517.
- Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-866-529-2517.
- Urdu - بلا قیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-866-529-2517 پر بات کریں
- Vietnamese - Đê`được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hằy gọi miền phi`đêh sô` 1-866-529-2517.
- Yiddish - פאר שפראך הילף אין אידיש רופט 1-866-529-2517 פון אפצאל.
- Yoruba - Fún irànlọwọ nípa èdè (Yorùbá) pe 1-866-529-2517 láí san owó kankan rárá.