### Important Questions

| What is the overall deductible? | For each Plan Year, In-Network: Individual $400 / Family $1,200. Out-of-Network: Individual $900 / Family $2,500. | 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. |
| Are there services covered before you meet your deductible? | Yes. Emergency care & prescription drugs; plus in-network office visits & preventive care are covered before you meet your deductible. | 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 [https://www.healthcare.gov/coverage/preventive-care-benefits/](https://www.healthcare.gov/coverage/preventive-care-benefits/). |
| Are there other deductibles for specific services? | No. | You don’t have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan? | In-Network: Individual $1,300 / Family $3,900. Out-of-Network: Individual $2,400 / Family $7,200. Prescription drugs: Individual $2,000 / Family $6,000. | 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. |
| What is not included in the out-of-pocket limit? | Premiums, balance-billing charges, health care this plan doesn’t cover & penalties for failure to obtain pre-authorization for services. | 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. See [www.aetna.com/docfind](http://www.aetna.com/docfind) or call 1-888-302-8742 for a list of in-network providers. | 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 a referral. |
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<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>$30 copay/visit, deductible doesn't apply</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$50 copay/visit, deductible doesn't apply</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>Deductible doesn't apply: $30 copay/visit for laboratory; $50 copay/visit for x-ray</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$100 copay/visit, deductible doesn't apply</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>10% coinsurance up to maximum/prescription, deductible doesn't apply: $20 (retail), $40 (mail order)</td>
<td>10% coinsurance up to maximum/prescription, deductible doesn't apply: $20 (retail), $40 (mail order)</td>
</tr>
</tbody>
</table>

Includes non-routine services by Gynecologist or Obstetrician.

None

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.

None

None

Covers 30 day supply (retail), 31-90 day supply (retail at CVS & mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA approved women's contraceptives in-network. Precertification required. Your cost will be higher for choosing Brand over Generics.
<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>administered by Caremark</td>
<td><strong>Preferred brand drugs</strong></td>
<td><strong>In-Network Provider</strong> <em>(You will pay the least)</em>: Deductible doesn't apply; 30% coinsurance up to $100 maximum/ prescription (retail), 20% coinsurance up to $100 maximum/ prescription (mail order)</td>
<td><strong>Out-of-Network Provider</strong> <em>(You will pay the most)</em>: Deductible doesn't apply; 30% coinsurance up to $100 maximum/ prescription (retail), 20% coinsurance up to $100 maximum/ prescription (mail order)</td>
</tr>
<tr>
<td></td>
<td><strong>Non-preferred brand drugs</strong></td>
<td>10% coinsurance with minimum &amp; maximum/prescription, deductible doesn't apply: $15 minimum &amp; $100 maximum (retail), $30 minimum &amp; $200 maximum (mail order)</td>
<td>10% coinsurance with minimum &amp; maximum/prescription, deductible doesn't apply: $15 minimum &amp; $100 maximum (retail), $30 minimum &amp; $200 maximum (mail order)</td>
</tr>
<tr>
<td></td>
<td><strong>Specialty drugs</strong></td>
<td>Applicable cost as noted above for generic or brand drugs</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>More information about prescription drug coverage is available at <a href="http://www.caremark.com">www.caremark.com</a></strong>*</td>
<td></td>
<td></td>
<td>Specialty drugs can be dispensed at CVS Pharmacies, CVS Specialty Mail Service, pharmacies at the Hospital of University of Pennsylvania, Penn Presbyterian Medical Center, Pennsylvania Hospital and Penn Medicine Radnor.</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$150 copay/visit, deductible doesn't apply</td>
<td>Out-of-network emergency use paid the same as in-network. No coverage for non-emergency use.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td>20% coinsurance, deductible doesn't apply</td>
<td>20% coinsurance, deductible doesn't apply</td>
<td>Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except if pre-authorized.</td>
</tr>
<tr>
<td>Urgent care</td>
<td>$50 copay/visit, deductible doesn't apply</td>
<td>$50 copay/visit, deductible doesn't apply</td>
<td>No coverage for non-urgent care.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>Outpatient services</td>
<td>Office: $15 copay/visit, deductible doesn't apply; other outpatient services: no charge</td>
<td>Office: 40% coinsurance, deductible doesn't apply; other outpatient services: 40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Inpatient services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Childbirth/delivery facility services</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>40% coinsurance</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>$25 copay/visit, deductible doesn't apply</td>
<td>40% coinsurance</td>
<td>60 visits/plan year for Physical &amp; Occupational Therapy combined, 60 visits/plan year for Speech Therapy.</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>No charge</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>180 days/plan year. Penalty of $400 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
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<tr>
<td>------------------------------------------</td>
<td>--------------------------------</td>
<td>--------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>No charge</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

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 (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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.)**

- Acupuncture - 10 visits/plan year for disease, injury & chronic pain.
- Bariatric surgery
- Chiropractic care - 60 visits/plan year.
- Hearing aids - $4,000 maximum/3 years.
- Infertility treatment - For more information & exceptions, see policy document provided by your employer or call the number on your ID card.
- Private-duty nursing
- Routine eye care (Adult) - 1 routine eye exam/24 months.

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 1-888-302-8742.
- 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](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:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-888-302-8742. You may also contact the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/ebsa/healthreform

- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.

- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

**Does this plan provide Minimum Essential Coverage?** Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet Minimum Value 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: $400
- 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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$400</td>
</tr>
<tr>
<td>Copayments</td>
<td>$200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,900</td>
</tr>
</tbody>
</table>

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

**The total Peg would pay is** $2,560

The plan would be responsible for the other costs of these EXAMPLE covered services.

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

- The plan's overall deductible: $400
- 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
- Diabetic supplies (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>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$2,300</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn't covered**
- Limits or exclusions: $20

**The total Joe would pay is** $2,320

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

- The plan's overall deductible: $400
- 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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$300</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$200</td>
</tr>
</tbody>
</table>

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

**The total Mia would pay is** $500
Assistive Technology
Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-302-8742.

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, disability, gender identity or sexual orientation.

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 companies, including Aetna Life Insurance Company and its affiliates (Aetna).
TTY: 711

Language Assistance:
To access language services at no cost to you, call 1-888-302-8742.

Albanian - Për shërbime përkthimi falas për ju, telefononi 1-888-302-8742.
Arabic - للحصول على الخدمات اللغوية دون أي تكلفة، الاتصال على الرقم 1-888-302-8742.
Armenian - Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-888-302-8742 հեռախոսահամարով:
Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-302-8742 tanpa dikenakan biaya.
Bengali-Bangala - আপনাকে বিনা মূল্যে ভাষা পরিবর্তন করতে হবে এই নম্বর প্রেরণ করুনঃ 1-888-982-3861.
Bisayan-Visayan - Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-888-302-8742.
Burmese - သင်၏အဖြစ်များ သင်ကြားမှုအားဖော်ထားသော ဘာသာစကားရရှိရန် 1-888-302-8742သိုင်ဖုန်းအဖြစ်နှုပ်။
Catalan - Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-888-302-8742.
Chamorro - Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-888-302-8742.
Chinese - 如欲使用免費語言服務，請致電 1-888-302-8742.
Choctaw - Anumpa tohsholi l toksvli ya peh pilla ho ish l paya hinla, l paya 1-888-302-8742.
Cushite - Tajaajiilootta afanaani garuu bilisaa ati argaachuuf, bilbili 1-888-302-8742.
Dutch - Voor gratis toegang tot taaldiensten, bell 1-888-302-8742.
French - Afin d'accéder aux services langagiers sans frais, composez le 1-888-302-8742.
French Creole - Pou jwenn sèvis lang gratis, rele 1-888-302-8742.
German - Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-888-302-8742 an.
Greek - Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-888-302-8742.
Gujarati - તમારી જાતિના ભાષાના સેવાની સેવાઓને પછી માટે, કોચ કરો1-888-302-8742.
No ka waʻa‘u ʻana me ka lawelawe ʻōlelo e kahea aku i kēia helu kelepona 1-888-302-8742. Kāki ʻole ʻia kēia kōkua nei.
1-888-302-8742

Punjabi - ਤੁਹਾਡੇ ਲਈ ਿਬਨ� ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤਕਰਨ ਲਈ, 1-888-302-8742 'ਤੇ ਫ਼ੋਨ ਕਰੋ।

Romanian - Pentru a accesa gratuit serviciile de limbă, apelați 1-888-302-8742.

Russian - Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-888-302-8742.

Samoan - Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala’au le 1-888-302-8742.

Serbo-Croatian - Za besplatne prevodilačke usluge pozovite 1-888-302-8742.

Spanish - Para acceder a los servicios de idiomas sin costo, llame al 1-888-302-8742.

Sudanic-Fulfude - Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-888-302-8742.

Swahili - Kupata huduma za lugha bila malipo kwako, piga 1-888-302-8742.

Syriac - ܐܸܢ ܐܣܢܝܼܩܵ ܝ̄̂ܬܘܼܢ ܥ̆̂ܠܚܹܠܡܼܿܬܹܐ ܐܕܗܼܿܝܼܿܪܬܵܐ ܒܠܸܫܵܢܵܐ ܡܼܿܓܵܢܵܐܝܼܬ

Tagalog - Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-888-302-8742.

Telugu - ఇది తెలంగాణ వచ్చడి ప్రస్తుతి ఎక్కడు ఎక్కడు, 1-888-302-8742 సారి ఇదే.

Thai - หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-888-302-8742.

Tongan - Kapau ‘oku ke fiema’u ta’etōtōngi ‘a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-888-302-8742.

Trukese - Ren omw kopwe angei aninisin eman chon awewe (ese kamo), kopwe kori 1-888-302-8742.

Turkish - Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-888-302-8742 numaranı arayın.

Ukrainian - Щоб отримати безкоштовний доступ до мовних послуг, здзвоніть за номером 1-888-302-8742.

Urdu - بالقیمت زبان سے متعلق خدمات حاصل کرنے کے لئے ، 3862-983-886-1 پر بات کریں.

Vietnamese - Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-888-302-8742.

Yiddish - צו גיטעט שפערן באידישןען אייזן פריז. צו אייר. 1-888-302-8742

Yoruba - Lati wọnú awọn isè èdè l’ófè fun ọ, pe 1-888-302-8742.