



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, call 1-800-735-8947 or visit <https://aetna.com>. 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 800-735-8947 to request a copy.

Important Questions	Answers	Why This Matters:
<u>What is the overall deductible?</u>	In-Network: Individual \$1,000 / Family \$2,000. Out-of-Network: Individual \$2,000 / Family \$4,000.	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> .
<u>Are there services covered before you meet your deductible?</u>	Yes. Network: preventive care, primary care & specialist visits, prenatal office visits, outpatient mental/behavioral health/substance abuse office visits, preventive vision exams & outpatient rehabilitation services.	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/
<u>Are there other deductibles for specific services?</u>	No.	You must pay all of the costs for these services up to the specific deductible amount before this <u>plan</u> begins to pay for these services
<u>What is the out-of-pocket limit for this plan?</u>	Medical In-Network: Individual \$5,250 / Family \$10,500. Out-of-Network: Individual \$10,500 / Family \$21,000. RX: Network: \$2,900 single/ \$5,800 family; Out-of-network: unlimited	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
<u>What is not included in the out-of-pocket limit?</u>	Premiums, <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover & penalties for failure to obtain <u>pre-authorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<u>Will you pay less if you use a network provider?</u>	Yes. See www.aetna.com/docfind or call 1-800-735-8947 for a list of in-network providers.	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.
<u>Do you need a referral to see a specialist?</u>	No.	You can see the <u>specialist</u> you choose without a <u>referral</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	\$30 <u>copay/visit</u> , <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$30 <u>copay/visit</u> , <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	None
	<u>Preventive care /screening</u> /immunization	No charge. Deductible does not apply	50% <u>coinsurance</u>	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)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.caremark.com	Generic drugs	\$10 <u>copay/prescription</u> (retail); \$20 <u>copay/prescription</u> (mail order). Medical <u>deductible</u> does not apply.	50% <u>coinsurance</u> ; Minimum \$50 for retail pharmacies. Medical <u>deductible</u> does not apply	<u>Prescription Drug Benefits</u> are administered by Sav-Rx Prescription Service. For detailed exclusions and <u>plan</u> limitations, refer to the Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust Summary <u>Plan Description</u> located at https://iwtfund.com . Non-maintenance medications are limited to a 30-day supply (retail).
	Brand <u>formulary</u> drugs	\$30 <u>copay/prescription</u> (retail); \$70 <u>copay/prescription</u> (mail order). Medical <u>deductible</u> does not apply.	50% <u>coinsurance</u> ; Minimum \$50 for retail pharmacies; Mail order not covered. Medical <u>deductible</u> does not apply.	Maintenance medications are limited to two 30-day supplies (retail). After that, you will need to move to a 90-day supply (mail order). If filling your maintenance medications (31-90 days) locally, please contact Sav-Rx at 888-662-

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)	
	Brand nonformulary/Specialty drugs	50% <u>coinsurance</u> with \$50 minimum/\$100 maximum (retail); \$125 <u>copay/prescription</u> (mail order). Medical <u>deductible</u> does not apply.	50% <u>coinsurance</u> ; Minimum \$50 for retail pharmacies; Mail order not covered. Medical <u>deductible</u> does not apply.	(IRON) 4766, 24/7/365 to opt out of filling at Mail Order. Affordable Care Act (ACA) medications are covered at \$0.00 copay. Please contact Sav-Rx for information. <u>Specialty drugs</u> are filled through Sav-Rx's preferred Specialty Pharmacy. Sav-Rx also has a High Impact Advocacy (HIA) Program that utilizes manufacturer coupons to help offset prescriptions costs. Sav-Rx will assist you with enrollment for the manufacturer coupon. Utilizing the Sav-Rx Specialty Pharmacy and the HIA Program will ensure your medications are a \$0 cost to you. If you opt out of using the preferred Specialty Pharmacy or the HIA Program, you will be responsible for 30% <u>coinsurance</u> on Specialty medications. Please contact Sav-Rx at 888-662-(IRON) 4766 to speak to a representative regarding your prescription benefits, agents are available 24 hours a day, 7 days a week. <u>Prescription Drug out-of-pocket limit: \$2,900/single or \$5,800/family in-network</u> ; no limit <u>out of network</u> .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center) Physician/surgeon fees	30% <u>coinsurance</u> 30% <u>coinsurance</u>	50% <u>coinsurance</u> 50% <u>coinsurance</u>	None None
	<u>Emergency room care</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Out-of-network emergency use paid the same as in-network.

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 immediate medical attention	<u>Emergency medical transportation</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Penalty of \$300 for failure to obtain <u>pre-authorization</u> for out-of-network care. None
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$30 <u>copay/visit</u> , <u>deductible</u> doesn't apply; other outpatient services: 30% <u>coinsurance</u>	Office & other outpatient services: 50% <u>coinsurance</u>	None
	Inpatient services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you are pregnant	Office visits	No charge. Deductible does not apply	50% <u>coinsurance</u>	<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). Penalty of \$300 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
	Childbirth/delivery professional services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	120 visits/calender year. Penalty of \$300 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Rehabilitation services</u>	\$30 <u>copay/visit</u> , <u>deductible</u> doesn't apply. Inpatient: 30% <u>coinsurance</u>	50% <u>coinsurance</u>	Speech therapy only covered for the correction of a speech impairment. 36 visits/calender year for Physical & Occupational Therapy, 20 visits/calender year for Speech Therapy, including outpatient hospital services.
	<u>Habilitation services</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None

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)	
	<u>Skilled nursing care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	180 days/calendar year. Penalty of \$300 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Durable medical equipment</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse. Covered up to the Maximum Allowable Amount for the standard item that is a Covered Service. Rental costs must not be more than the purchase price.
	<u>Hospice services</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Penalty of \$300 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If your child needs dental or eye care	Eye exam	\$30 <u>copay/visit</u> , <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	1 routine eye exam/12 months.
	Glasses	Not covered	Not covered	You must pay 100% of this service, even from a network provider.
	Dental check-up	Not covered	Not covered	You must pay 100% of this service, even from a network provider.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Infertility Treatment
- Routine foot care
- Weight loss programs
- Routine eye Care, except eye exams

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

- Bariatric surgery - \$10,000 maximum/lifetime.
- Chiropractic care - 12 visits/calendar year.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Private-duty nursing
- Emergency care when traveling outside the U.S. or Canada

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:

- 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 1-800-370-4526. 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 <u>plan's</u> <u>overall deductible</u>	\$1,000
■ <u>Specialist copayment</u>	\$30
■ <u>Hospital (facility) coinsurance</u>	30%
■ <u>Other coinsurance</u>	30%

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
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$3,200
<i>What isn't covered</i>	
Limits or exclusions	\$70
The total Peg would pay is	\$4,270

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> <u>overall deductible</u>	\$1,000
■ <u>Specialist copayment</u>	\$30
■ <u>Hospital (facility) coinsurance</u>	30%
■ <u>Other coinsurance</u>	30%

This EXAMPLE event includes services like:

Primary care provider office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Diabetic supplies (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$4,300
The total Joe would pay is	\$4,700

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> <u>overall deductible</u>	\$1,000
■ <u>Specialist copayment</u>	\$30
■ <u>Hospital (facility) coinsurance</u>	30%
■ <u>Other coinsurance</u>	30%

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
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$10
The total Mia would pay is	\$1,510

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: 1-800-370-4526.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-370-4526.

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 1-800-370-4526.

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للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء التصال على الرقم 1-800-370-4526

Անվանական ծառայություններից օգտվելու համար զանգահարել 1-800-370-4526 հեռախոսահամարով:

Carolinian ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-370-4526.

Chlorophyll a (µg m⁻²) 0.00 0.02 0.04 0.06 0.08 0.10 0.12 0.14 0.16 0.18 0.20 0.22 0.24 0.26 0.28 0.30 0.32 0.34 0.36 0.38 0.40 0.42 0.44 0.46 0.48 0.50 0.52 0.54 0.56 0.58 0.60 0.62 0.64 0.66 0.68 0.70 0.72 0.74 0.76 0.78 0.80 0.82 0.84 0.86 0.88 0.90 0.92 0.94 0.96 0.98 1.00 1.02 1.04 1.06 1.08 1.10 1.12 1.14 1.16 1.18 1.20 1.22 1.24 1.26 1.28 1.30 1.32 1.34 1.36 1.38 1.40 1.42 1.44 1.46 1.48 1.50 1.52 1.54 1.56 1.58 1.60 1.62 1.64 1.66 1.68 1.70 1.72 1.74 1.76 1.78 1.80 1.82 1.84 1.86 1.88 1.90 1.92 1.94 1.96 1.98 2.00 2.02 2.04 2.06 2.08 2.10 2.12 2.14 2.16 2.18 2.20 2.22 2.24 2.26 2.28 2.30 2.32 2.34 2.36 2.38 2.40 2.42 2.44 2.46 2.48 2.50 2.52 2.54 2.56 2.58 2.60 2.62 2.64 2.66 2.68 2.70 2.72 2.74 2.76 2.78 2.80 2.82 2.84 2.86 2.88 2.90 2.92 2.94 2.96 2.98 3.00 3.02 3.04 3.06 3.08 3.10 3.12 3.14 3.16 3.18 3.20 3.22 3.24 3.26 3.28 3.30 3.32 3.34 3.36 3.38 3.40 3.42 3.44 3.46 3.48 3.50 3.52 3.54 3.56 3.58 3.60 3.62 3.64 3.66 3.68 3.70 3.72 3.74 3.76 3.78 3.80 3.82 3.84 3.86 3.88 3.90 3.92 3.94 3.96 3.98 4.00 4.02 4.04 4.06 4.08 4.10 4.12 4.14 4.16 4.18 4.20 4.22 4.24 4.26 4.28 4.30 4.32 4.34 4.36 4.38 4.40 4.42 4.44 4.46 4.48 4.50 4.52 4.54 4.56 4.58 4.60 4.62 4.64 4.66 4.68 4.70 4.72 4.74 4.76 4.78 4.80 4.82 4.84 4.86 4.88 4.90 4.92 4.94 4.96 4.98 5.00 5.02 5.04 5.06 5.08 5.10 5.12 5.14 5.16 5.18 5.20 5.22 5.24 5.26 5.28 5.30 5.32 5.34 5.36 5.38 5.40 5.42 5.44 5.46 5.48 5.50 5.52 5.54 5.56 5.58 5.60 5.62 5.64 5.66 5.68 5.70 5.72 5.74 5.76 5.78 5.80 5.82 5.84 5.86 5.88 5.90 5.92 5.94 5.96 5.98 6.00 6.02 6.04 6.06 6.08 6.10 6.12 6.14 6.16 6.18 6.20 6.22 6.24 6.26 6.28 6.30 6.32 6.34 6.36 6.38 6.40 6.42 6.44 6.46 6.48 6.50 6.52 6.54 6.56 6.58 6.60 6.62 6.64 6.66 6.68 6.70 6.72 6.74 6.76 6.78 6.80 6.82 6.84 6.86 6.88 6.90 6.92 6.94 6.96 6.98 7.00 7.02 7.04 7.06 7.08 7.10 7.12 7.14 7.16 7.18 7.20 7.22 7.24 7.26 7.28 7.30 7.32 7.34 7.36 7.38 7.40 7.42 7.44 7.46 7.48 7.50 7.52 7.54 7.56 7.58 7.60 7.62 7.64 7.66 7.68 7.70 7.72 7.74 7.76 7.78 7.80 7.82 7.84 7.86 7.88 7.90 7.92 7.94 7.96 7.98 8.00 8.02 8.04 8.06 8.08 8.10 8.12 8.14 8.16 8.18 8.20 8.22 8.24 8.26 8.28 8.30 8.32 8.34 8.36 8.38 8.40 8.42 8.44 8.46 8.48 8.50 8.52 8.54 8.56 8.58 8.60 8.62 8.64 8.66 8.68 8.70 8.72 8.74 8.76 8.78 8.80 8.82 8.84 8.86 8.88 8.90 8.92 8.94 8.96 8.98 9.00 9.02 9.04 9.06 9.08 9.10 9.12 9.14 9.16 9.18 9.20 9.22 9.24 9.26 9.28 9.30 9.32 9.34 9.36 9.38 9.40 9.42 9.44 9.46 9.48 9.50 9.52 9.54 9.56 9.58 9.60 9.62 9.64 9.66 9.68 9.70 9.72 9.74 9.76 9.78 9.80 9.82 9.84 9.86 9.88 9.90 9.92 9.94 9.96 9.98 10.00

Chinese Traditional - 如欲使用免費語言服務 請致電 1-800-370-4526

Tajaa jii loota afaanii garuu bilisaa ati argaachuuuf bilibili 1-800-370-4526

French - Afin d'accéder aux services langagiers sans frais, composez le 1-800-370-4526.

French Creole (Haitian)- Pou jwenn sèvis lang gratis, rele 1-800-370-4526.

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-800-370-4526 an.

Greek - Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-800-370-4526.

Gujarati - તમારેકોઈ જતના ઘર્યવિના ભાષાની સે વિના ઓનિ પણોર માટે. કોલ કરોર 1-800-370-4526.

आपके लिए हिंदी की सीखने की सुविधा उपलब्ध करता है। 1-800-370-4526 पर कॉल करें।

Xav tau key nab txhais lus tsis muai nqj them rau koi, hu 1-800-370-4526.

Italian - Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-800-370-4526.

言語サービスを無料でご利用いただくには、1-800-370-4526までお電話ください。

Karen - လာတ်ကမန်ကိုယ်အတ်မာစာအတ်ပံးတ်မာတဖ်လာတအိုဒီးအပျေလာကဘုံဟုံအိုးအကိုးဘုံနှင့် ကို 1-800-370-4526 တာရှိ။

Korean - 무료 언어 서비스를 이용하려면 1-800-370-4526 번으로 전화해 주십시오.

ເພື່ອຂໍ້ໃຈກາງເວົາກາງເງົາຮາໂຄມ່ນໍ້າຮ່ວມຄ່າຕໍ່ກັນ ກ່າວ່າ ໃຫ້ໃກ້ຫາເບີ 1-800-370-4526

Cambodian -

Navajo - T'áá ni nizaad k'ehjí bee níká a'doowoł doo bááh ílinígóó koji' hólne' 1-800-370-4526.

Pennsylvania Dutch - Um Schprooch Services zu griege mitaus Koscht, ruff 1-800-370-4526.

برای دسترسی به خدمات زبان به طور رایگان، با شماره 4526-4520-1800 تماس بگیرید.

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonić 1-800-370-4526.

Portuguese - Para acessar os serviços de idiomas sem custo para você, ligue para 1-800-370-4526.

ਪੁਨਜੀ - ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-800-370-4526 'ਤੇ ਫੋਨ ਕਰੋ।

For free assistance, please call 1-800-370-4526.

Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-800-370-4526.

Serbo-Croatian - Za besplatne prevodilačke usluge pozovite 1-800-370-4526.

Spanish - Para acceder a los servicios de idiomas sin costo, llame al 1-800-370-4526.

Syriac-Assyrian - 1-800-370-4526.    

Tagalog - Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-800-370-4526.

หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-800-370-4526.

Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-800-370-4526.

Vietnamese - Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-800-370-4526.

אָזְכוֹרִיט שְׁפָרָר בְּאַדִּיבָּגָעָן אַיִן קְיַיִן פְּרִיָּן צַו אַיִל, רְוָפָן 1-800-370-4526

Yoruba - Lati wonú awọn ise èdè l’ofe fun o, pe 1-800-370-4526.