### Important Questions | Answers | Why This Matters:

**What is the overall deductible?**

| Tier 1: Select Care (SLU Care): Individual: $100/ Family: $200. Tier 2: In-Network: Individual: $500/ Family: $1,000. Tier 3: Out-of-Network: Individual: $1,000/ Family: $2,000 per Plan Year. | 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. Prescription drugs; plus in-network 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/.

**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?**

| Tier 1: Select Care (SLU Care): Individual: $2,500/ Family: $5,000 per Plan Year. Tier 2: In-Network: Individual: $5,650/ Family: $11,300 per Plan Year. Tier 3: Out-of-network: Unlimited. | 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 or call 1-877-381-3544 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>Tier 1: Your Cost if You Use a Select Care Provider (SLU Care)</th>
<th>Tier 2: Your Cost if You Use a In-Network Provider (Aetna)</th>
<th>Tier 3: Your Cost if You Use an Out-of-Network Provider (Aetna)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>No Charge</td>
<td>$50 copay/visit, deductible doesn’t apply</td>
<td>30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>No Charge</td>
<td>$50 copay/visit, deductible doesn’t apply</td>
<td>30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care /screening /immunization</td>
<td>No Charge</td>
<td>No Charge</td>
<td>30% coinsurance, except deductible doesn’t apply to immunizations up to age 5</td>
<td>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.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>0% coinsurance</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>0% coinsurance</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic drugs</td>
<td>Not Applicable</td>
<td>Copay/prescription, deductible doesn’t apply: $20 (retail) / $40 (mail order)</td>
<td>Copay/prescription, deductible doesn’t apply: $20 (retail)</td>
<td>Covers 30 day supply (retail). 31-90 day supply (mail order) Includes contraceptive drugs &amp; devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women’s contraceptives in-network.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>Not Applicable</td>
<td>Copay/prescription, deductible doesn’t apply: $50 (retail) / $100 (mail order)</td>
<td>Copay/prescription, deductible doesn’t apply: $50 (retail)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>Not Applicable</td>
<td>Copay/prescription, deductible doesn’t apply: $80 (retail) / $160 (mail order)</td>
<td>Copay/prescription, deductible doesn’t apply: $80 (retail)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Not Applicable</td>
<td>Applicable cost as noted above for generic or brand drugs</td>
<td>Applicable cost as noted above for generic or brand drugs</td>
<td>None</td>
</tr>
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<td>Common Medical Event</td>
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<td>------------------------------------------------------------</td>
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<td>----------------------------------------------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$50 copay/visit, deductible doesn't apply</td>
<td>$200 copay/visit, deductible doesn't apply</td>
<td>30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>$50 copay/visit, deductible doesn't apply</td>
<td>$200 copay/visit, deductible doesn't apply</td>
<td>30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care</td>
<td>$150 copay/visit, deductible doesn't apply</td>
<td>$150 copay/visit, deductible doesn't apply</td>
<td>$150 copay/visit, deductible doesn't apply</td>
<td>No coverage for non-emergency use.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>Not Applicable</td>
<td>0% coinsurance</td>
<td>0% coinsurance</td>
<td>Balance billing may apply for out-of-network provider, refer to policy.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>Not Applicable</td>
<td>$50 copay/visit, deductible doesn't apply</td>
<td>$75 copay/visit, deductible doesn't apply</td>
<td>No coverage for non-urgent use.</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>No Charge</td>
<td>$565 copay/per admission, deductible doesn't apply</td>
<td>30% coinsurance</td>
<td>Penalty of $500 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No Charge</td>
<td>20% coinsurance, deductible doesn't apply</td>
<td>30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need mental health or behavioral health, services</strong></td>
<td>Outpatient services</td>
<td>Office &amp; other outpatient services: No Charge</td>
<td>Office &amp; other outpatient services: No charge</td>
<td>Office &amp; other outpatient services: 30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>No Charge</td>
<td>$565 copay/per admission, deductible doesn't apply</td>
<td>30% coinsurance</td>
<td>Penalty of $500 for failure to obtain pre-authorization for out-of-network care.</td>
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<td>---------------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>If you need substance abuse services</td>
<td>Outpatient services</td>
<td>Office &amp; other outpatient services: No charge</td>
<td>Office &amp; other outpatient services: No charge</td>
<td>Office &amp; other outpatient services: 30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>Not Applicable</td>
<td>$565 copay/per admission, deductible doesn't apply</td>
<td>30% coinsurance</td>
<td>Penalty of $500 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No Charge</td>
<td>No Charge</td>
<td>30% coinsurance</td>
<td>Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of $500 for failure to obtain pre-authorization for out-of-network care may apply.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No Charge</td>
<td>20% coinsurance, deductible doesn't apply</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>No Charge</td>
<td>$565 copay/per admission, deductible doesn't apply</td>
<td>30% 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>Not Applicable</td>
<td>0% coinsurance</td>
<td>30% coinsurance</td>
<td>100 visits/plan year</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>No Charge</td>
<td>$50 copay/visit, deductible doesn't apply</td>
<td>30% coinsurance</td>
<td>Includes Physical, Occupational &amp; Speech Therapy.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>No Charge</td>
<td>$50 copay/visit, deductible doesn't apply</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>Not Applicable</td>
<td>0% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
<td>Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>Not Applicable</td>
<td>0% coinsurance</td>
<td>30% coinsurance</td>
<td>Penalty of $500 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
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<td>---------------------------------------------------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>No Charge</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td>1 routine eye exam/plan year. Covered through the end of the month in which the covered person turns 19.</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>No Charge</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td>1 pair of glasses or lenses/plan year. Covered through the end of the month in which the covered person turns 19.</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>Not Applicable</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td>Covered through the end of the month in which the covered person turns 19.</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.**

- Acupuncture (except in lieu of anesthesia)
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Routine foot care
- Weight loss programs - Except for required preventive services.

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

- Chiropractic care
- Hearing aids – 1 hearing aid per ear/plan year
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing – 82 visits/plan year
- Routine eye care (Adult)
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: Missouri Division of Insurance, 301 W. High St., Room 350, Jefferson City, MO 65101, (573) 751-4126, http://insurance.mo.gov/consumers.

- For more information on your rights to continue coverage, contact the plan at 1-877-375-7905. 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 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 1-877-381-3544.
- Additionally, a consumer assistance program can help you file your appeal. Contact Missouri Division of Insurance 301 W. High St., Room 350, Jefferson City, MO 65101, (573) 751-4126, https://insurance.mo.gov/consumers/.

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

Does this plan meet 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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe's type 2 Diabetes</th>
<th>Mia's Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9 months of in-network pre-natal care and a hospital delivery)</td>
<td>(a year of routine in-network care of a well-controlled condition)</td>
<td>(in-network emergency room visit and follow up care)</td>
</tr>
</tbody>
</table>

- The plan's overall deductible: $100
- Specialist copayment: $0
- Hospital (facility) coinsurance: 0%
- Other coinsurance: 0%

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

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$100</td>
</tr>
<tr>
<td>Copayments</td>
<td>$80</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

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

The total Peg would pay is $240

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

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$100</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,300</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

What isn't covered:
- Limits or exclusions: $50

The total Joe would pay is $1,420

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

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$100</td>
</tr>
<tr>
<td>Copayments</td>
<td>$200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

What isn't covered:
- Limits or exclusions: $30

The total Mia would pay is $300

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 1-877-381-3544.

Smartphone or Tablet
To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination
Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, 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 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: PO Box 24030 Fresno, CA 93779)

1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705)

Email: 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.
TTY: 711

Language Assistance:

For language assistance in your language call 1-877-381-3544 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-877-381-3544.
Amharic - እንጆም ልማት እና እንጆም ልማት 1-877-381-3544 የልጠ� የርጉ-
Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-877-381-3544.
Armenian - Լեզվի գործադիր աջակցության (հայերեն) զանգի 1-877-381-3544 շարունակ գնում
Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-877-381-3544 tanpa dikenakan biaya.
Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-877-381-3544 ku busa
Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-877-381-3544-তে কল করুন।
Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-877-381-3544 nga walay bayad.
Burmese - မိသားစုစေးနှင့် ပတ်သက်တဲ့ ပိုင်းခြား အခြေခံ အမှတ် 1-877-381-3544.
Catalan - Per rebre assistència en (català), truqui al número gratuït 1-877-381-3544.
Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-877-381-3544 sin gåstu.
Cherokee - ᎠᏍᏗᏍᏗ ᎨᏍᎩᏍᏗᏍᏗ ᎨᏍᏗᏍᏗ ᎨᏍᏗᏍᏗ (GWW) ᎨᏍᎩᏍᏗ (GWV) 1-877-381-3544 ᎨᏍᏗᏍᏗ ᎨᏍᏗᏍᏗ ᎨᏍᎩᏍᏗ (GWW).
Chinese - 欲取得繁體中文語言協助，請撥打 1-877-381-3544，無需付費。
Choctaw - (Chahta) anumpa ya apela a chi l paya hinla 1-877-381-3544.
Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbila 1-877-381-3544 irratti bilisaan bilbila.
Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-877-381-3544.
French - Pour une assistance linguistique en français appeler le 1-877-381-3544 sans frais.
French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-877-381-3544 gratis.
German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-877-381-3544 an.
Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-877-381-3544 χωρίς χρέωση.
Gujarati - ગુજરાતીમાં ભાષાના સહાય માટે કોઈ પણ અર્થ વગર 1-877-381-3544 પર કોલ કરો.

Hindī में भाषा सहायता के लिए, 1-877-381-3544 पर मुफ्त कॉल करें।

Hmoob - Maka enyemaka asusu na Igbo kpoo 1-877-381-3544 na akwughì ñgwò o bula

Ibo - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-877-381-3544 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-877-381-3544.

Japanese - 日本語で援助をご希望の方は、1-877-381-3544 まで無料でお電話ください。

Karen - 1-877-381-3544

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-877-381-3544 번으로 전화해 주십시오.

Kru-Bassa - 1-877-381-3544

Kurdish - 1-877-381-3544

Laotian - 1-877-381-3544

Marathi - 1-877-381-3544 क्रमांकाकारकोणत्याहीकर्णिशिवायकॉलकरा.

Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-877-381-3544 ilo eejelok wōnān.

Micronesian-Pohnpeyan - Ohng palien sawas en souk kawewe ni omw lokaia Ponape koahl 1-877-381-3544 ni sohte isais.

Mon-Khmer, Cambodian - 1-877-381-3544

Navajo - T’áá shi shizaad k’ehjí bee shiká a’doo wol ninízingo Diné k’ehjí koji’ t’áá jíík’ee hólne’ 1-877-381-3544

Nepali - (लेखलो) मा नि:शुल्क भाषा सहायता पाउनका लागि 1-877-381-3544 मा फोन गर्नुहोस्।

Nilotic-Dinka - Tën kwoony ê thok ê Thuonjān col 1-877-381-3544 kecín ayöc.

Norwegian - For språkassistanse på norsk, ring 1-877-381-3544 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਹਿੰਦੀ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਪਾਉਣਕਾ ਲਾਗੀ 1-877-381-3544 ਮਾ ਫੋਨ ਗਰਨਹੋਣਾ।


Persian - برای راهنمانی به زبان فارسی با شماره 1-877-381-3544 بدون هیچ هزینه ای تماس بگیرید. انگلیسی

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-877-381-3544.
Para obter assistência linguística em português ligue para o 1-877-381-3544 gratuitamente.

Пентру асистенță lingvistică în românește telefonați la numărul gratuit 1-877-381-3544

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-877-381-3544.

Mo fesoasoani tau gagana le Gagana Samoa vala'au le 1-877-381-3544 e aunoa ma se totonogia.

Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-877-381-3544.

Para obtener asistencia lingüística en español, llame sin cargo al 1-877-381-3544.

Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-877-381-3544. Njodi woo fawaaki on.

Ukihitajia usaidizi katika lugha ya Kiswahili piga simu kwa 1-877-381-3544 bila malipo.

Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-877-381-3544 nang walang bayad.

మాంబి భాషా నిర్ధారణ విస్తృతి ఇబ్బంది 1-877-381-3544 ను ద్వారా వెలుస్తుంది. (మాంగా)

สำหรับความช่วยเหลือทางภาษาเป็น ภาษาไทย โทร 1-877-381-3544 ฟรีไม่มีค่าใช้จ่าย

Kapau ‘oku fiema ‘u hā tokoni ‘i he lea faka-Tonga telefoni 1-877-381-3544 ‘o ‘ikai hā ōtōngi.

Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-877-381-3544 nge esapw kamé ngonuk.

(Dil) çağrısı dil yardımı için. Hiçbir ücret ödedemen 1-877-381-3544.

Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-877-381-3544.

ا ب ز ک ل ک ت م ر ب 1-877-381-3544-3544.

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-877-381-3544.

אכוז שפואארו יהלוך איו אידיש רוטן unloaded. 1-877-381-3544

Fún irànìwọ̀ nípa èdè (Yorùbá) pe 1-877-381-3544 lái san owó kankan rárá.