



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, www.HealthReformPlanSBC.com or by calling 1-800-370-4526. 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 1-800-370-4526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	UMC In- <u>Network</u> : Individual \$1,500 / Family \$3,000. Out-of- <u>Network</u> : Individual \$2,750 / Family \$5,500.	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. In- <u>network</u> office visits, <u>prescription drugs</u> & <u>preventive care</u> are covered before you meet your <u>deductible</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>?	UMC In- <u>Network</u> : Individual \$5,000 / Family \$10,000. Out-of- <u>Network</u> : Individual NONE / Family NONE.	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> , balance-billing charges & 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 www.aetna.com/docfind or call 1-800-370-4526 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>?	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
		UMC 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	\$45 <u>copay</u> /visit, <u>deductible</u> doesn't apply	40% <u>coinsurance</u> after <u>deductible</u>	None
	<u>Specialist</u> visit	\$45 <u>copay</u> /visit, <u>deductible</u> doesn't apply	40% <u>coinsurance</u> after <u>deductible</u>	None
	<u>Preventive care</u> / <u>screening</u> /immunization	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)	Free standing facility: No charge (laboratory), 20% <u>coinsurance</u> (x-ray) after deductible	40% <u>coinsurance</u> after <u>deductible</u>	None
	Imaging (CT/PET scans, MRIs)	Free standing facility: 20% <u>coinsurance</u> ; Outpatient hospital: 20% <u>coinsurance</u> after \$150 <u>copay</u> /visit, except 5% <u>coinsurance</u> after \$150 <u>copay</u> /visit	40% <u>coinsurance</u> after <u>deductible</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		UMC In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.aetnapharmacy.com/standard	Generic drugs	<u>Copay/prescription, deductible</u> doesn't apply: \$15 for 30 day supply, \$45 for 90 day supply, \$30 for 31-90 day supply (mail order)	40% <u>coinsurance</u> after <u>copay/prescription, deductible</u> doesn't apply: \$15 (retail)	Covers 30 day supply (retail), 31-90 day supply (retail at Extended Day Supply Network Pharmacy & mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in- <u>network</u> . Review your <u>formulary</u> for prescriptions requiring step therapy for coverage. Your cost will be higher for choosing Brand over Generics. Review your Aetna Extended Day Supply <u>Network provider</u> directory for a list of <u>network providers</u> .
	Preferred brand drugs	<u>Copay/prescription, deductible</u> doesn't apply: \$30 for 30 day supply, \$90 for 90 day supply, \$60 for 31-90 day supply (mail order)	40% <u>coinsurance</u> after <u>copay/prescription, deductible</u> doesn't apply: \$30 (retail)	
	Non-preferred brand drugs	<u>Copay/prescription, deductible</u> doesn't apply: \$45 for 30 day supply, \$135 for 90 day supply, \$90 for 31-90 day supply (mail order)	40% <u>coinsurance</u> after <u>copay/prescription, deductible</u> doesn't apply: \$45 (retail)	
	<u>Specialty drugs</u>	Applicable cost as noted above for generic or brand drugs	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u> after \$150 <u>copay/visit</u>	40% <u>coinsurance</u> after <u>deductible</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u> after <u>deductible</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		UMC 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 room care</u>	20% <u>coinsurance</u> after \$250 <u>copay</u> /visit	20% <u>coinsurance</u> after \$250 <u>copay</u> /visit	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . 20% <u>coinsurance</u> after \$250 <u>copay</u> /visit. (For non-emergency use for out-of-network 50% coinsurance after \$500 copay, except no charge outside the U.S.)
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> .
	<u>Urgent care</u>	\$45 <u>copay</u> /visit, <u>deductible</u> doesn't apply	40% <u>coinsurance</u> after <u>deductible</u>	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u> after \$200 <u>copay</u> /stay	40% <u>coinsurance</u> after <u>deductible</u>	<u>Pre-authorization</u> required for out-of-network care.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u> after <u>deductible</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: \$45 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Office & other outpatient services: 40% <u>coinsurance</u>	None
	Inpatient services	20% <u>coinsurance</u> after \$200 <u>copay</u> /stay	40% <u>coinsurance</u> after <u>deductible</u>	<u>Pre-authorization</u> required for out-of-network care.
If you are pregnant	Office visits	No charge	40% <u>coinsurance</u> after <u>deductible</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.) <u>Pre-authorization</u> for out-of-network care may apply.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u> after <u>deductible</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u> after \$200 <u>copay</u> /stay	40% <u>coinsurance</u> after <u>deductible</u>	
If you need help recovering or have	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u> after <u>deductible</u>	<u>Pre-authorization</u> required for out-of-network care.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		UMC In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
other special health needs	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u> after deductible	None
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u> after deductible	None
	<u>Skilled nursing care</u>	20% <u>coinsurance</u> after \$200 <u>copay/visit</u>	40% <u>coinsurance</u> after deductible	60 days/calendar year. <u>Pre-authorization</u> required for out-of-network care.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u> after deductible	40% <u>coinsurance</u> after deductible	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>	40% <u>coinsurance</u> after deductible	<u>Pre-authorization</u> required for out-of-network care.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

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
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult & Child)
- 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 - 28 visits/calendar year.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Private-duty nursing

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 plan's overall deductible \$1,500
- Specialist copayment \$45
- Hospital (facility) copayment \$200
- Other copayment/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:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$840
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,600

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

- The plan's overall deductible \$1,500
- Specialist copayment \$45
- Hospital (facility) copayment \$200
- Other copayment/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:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$900
<u>Coinsurance</u>	\$40
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,000

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

- The plan's overall deductible \$1,500
- Specialist copayment \$45
- Hospital (facility) copayment \$200
- Other copayment/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:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$250
<u>Coinsurance</u>	\$560
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,310

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 866-393-0002.

Smartphone or Tablet

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

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, 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 subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates.

- Hindi - हन्दिी में भाषा सहायता के लएि, 1-800-370-4526 पर मुफ्त कॉल करें।
- Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-370-4526.
- Ibo - Maka enyemaka asụsụ na Igbo kpọọ 1-800-370-4526 na akwughị ugwọ ọ bụla
- Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-370-4526 nga awan ti bayadanyo.
- Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-370-4526.
- Japanese - 日本語で援助をご希望の方は、1-800-370-4526 まで無料でお電話ください。
- Karen - လာဝာ်မစာလာ်ကလိာ်ကိ်အကိ် ကိ် 1-800-370-4526 လာဝာ်အိ်ဒီးလာ်ဘူ်လာ်စုဘူ်
- Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-370-4526 번으로 전화해 주십시오.
- Kru-Bassa - Be'm'ké gbo-kpá-kpá dyé pídyi dé Baśwó`wuđũñ wěë, dá 1-800-370-4526
- Kurdish - برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 به خۆرای یه یه مندی بکن.
- Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-800-370-4526 ໂດຍບໍ່ເສຍຄ່າໂທ.
- Marathi - कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-800-370-4526 वर फोन करा.
- Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-370-4526 ilo ejjelok wōnān.
- Micronesian - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-370-4526 ni sohte isais.
- Pohnpeyan - ສຸຍາກບໍ່ຕ້ອງສາລາດ ກາລາຊຸຍ ສຸຍຍຸສັດຊອຣ ອາກສ່ລາ 1-800-370-4526 ສາຍສັດສັດຊຸຍ
- Mon-Khmer, Cambodian - សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-800-370-4526 ដោយឥតគិតថ្លៃ។
- Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-800-370-4526
- Nepali - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-800-370-4526 मा फोन गर्नुहोस् ।
- Nilotic-Dinka - Tën kuwoony è thok è Thuonjäŋ cöl 1-800-370-4526 kec'in ayöc.
- Norwegian - For språkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt.
- Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-370-4526 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।
- Pennsylvania Dutch - Fer Hilfe in Deutsch, ruf: 1-800-370-4526 aa. Es Aaruf koschtet nix.
- Persian - برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
- Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-370-4526.
- Portuguese - Para obter assistência linguística em português ligue para o 1-800-370-4526 gratuitamente.
- Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-800-370-4526

- Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-370-4526.
- Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-800-370-4526 e aunoa ma se totogi.
- Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-370-4526.
- Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-800-370-4526.
- Sudanic-Fulfude - Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-800-370-4526. Njodi woo fawaaki on.
- Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-370-4526 bila malipo.
- Syriac - ܠܟܘܢ ܠܗܘܠܐܢܘܢ ܠܗܘܠܐܢܘܢ ܠܗܘܠܐܢܘܢ ܠܗܘܠܐܢܘܢ ܠܗܘܠܐܢܘܢ ܠܗܘܠܐܢܘܢ ܠܗܘܠܐܢܘܢ ܠܗܘܠܐܢܘܢ ܠܗܘܠܐܢܘܢ ܠܗܘܠܐܢܘܢ ܠܗܘܠܐܢܘܢ 1-800-370-4526 ܠܗܘܠܐܢܘܢ.
- Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-370-4526 nang walang bayad.
- Telugu - భాషలో సాయం కోరకు ఎలాంటి ఖర్చు లేకుండా 1-800-370-4526 కు కాల్ చేయండి. (తెలుగు)
- Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-800-370-4526 ฟรีไม่มีค่าใช้จ่าย
- Tongan - Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-800-370-4526 ‘o ‘ikai hā ʻōtōngi.
- Trukese - Ren ánninnisin chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-800-370-4526 nge esapw kamé ngonuk.
- Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemedi 1-800-370-4526.
- Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-370-4526.
- Urdu - بلا قیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-800-370-4526 پر بات کریں۔
- Vietnamese - Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-800-370-4526.
- Yiddish - פאר שפראך הילף אין אידיש רופט 1-800-370-4526 פון אפצאל.
- Yoruba - Fún ìrànṣọwọ nípa èdè (Yorùbá) pe 1-800-370-4526 láí san owó kankan rárá.