



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:
<u>What is the overall deductible?</u>	\$0. Out-of-Network: Individual \$500 / Family \$1,000.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family deductible.
<u>Are there services covered before you meet your deductible?</u>	Yes. Emergency care & <u>prescription drugs</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/
<u>Are there other deductibles for specific services?</u>	No.	You don't have to meet <u>deductibles</u> for specific services.
<u>What is the out-of-pocket limit for this plan?</u>	In- <u>Network</u> : Individual \$800 / Family \$1,600. Out-of-Network: Individual \$800 / Family \$1,600. <u>Prescription drugs</u> : Individual \$400 / Family \$800.	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>	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover & penalties for failure to obtain pre-authorization 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 1-800-370-4526 for a list of in- <u>network</u> 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	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply, except no charge for selected PCP	20% <u>coinsurance</u> after \$15 <u>copay</u> /visit	None
	<u>Specialist</u> visit	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	20% <u>coinsurance</u> after \$15 <u>copay</u> /visit	None
	<u>Preventive care /screening</u> /immunization	No charge	Not covered, except 20% <u>coinsurance</u> for mammograms	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)	No charge	20% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	No charge	20% <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)	
<p>If you need drugs to treat your illness or condition</p> <p><u>Prescription drug coverage</u> is administered by Sav-Rx</p> <p>More information about <u>prescription drug coverage</u> is available at www.savrx.com</p>	<p>Generic drugs</p> <p>Preferred brand drugs</p>	<p><u>Copay/prescription, deductible</u> doesn't apply: Value Based \$4 for 30 day supply, \$8 for 60 day supply, \$12 for 90 day supply (retail), \$8 for 31-90 day supply (mail order); Preferred Generic \$8 for 30 day supply, \$16 for 60 day supply, \$24 for 90 day supply (retail), \$16 for 31-90 day supply (mail order) Insulin: no charge</p> <p><u>Copay/prescription, deductible</u> doesn't apply: \$25 for 30 day supply, \$50 for 60 day supply, \$75 for 90 day supply (retail); \$50 for 31-90 day supply (mail order) Insulin: no charge</p>	<p><u>Copay/prescription, deductible</u> doesn't apply: \$13 for 30 day supply, \$26 for 60 day supply, \$39 for 90 day supply (retail) Insulin: \$13 <u>copay/prescription</u></p> <p><u>Copay/prescription, deductible</u> doesn't apply: \$30 for 30 day supply, \$60 for 60 day supply, \$90 for 90 day supply (retail) Insulin: \$30 <u>copay/prescription</u></p>	<p>Covers 90 day supply (retail & mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives <u>in-network</u>. Review your <u>formulary</u> for prescriptions requiring precertification or step therapy for coverage. Your cost will be higher for choosing Brand over Generics.</p>

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)	
	Non-preferred brand drugs	<u>Copay/prescription, deductible</u> doesn't apply: \$50 for 30 day supply, \$100 for 60 day supply, \$150 for 90 day supply (retail); \$100 for 31-90 day supply (mail order) Insulin: \$25 <u>copay/prescription</u>	<u>Copay/prescription, deductible</u> doesn't apply: \$55 for 30 day supply, \$110 for 60 day supply, \$165 for 90 day supply (retail) Insulin: \$35 <u>copay/prescription</u>	First prescription fill at a retail pharmacy or Sav-Rx Prescription Services. Subsequent fills must be through Sav-Rx Prescription Services.
	<u>Specialty drugs</u>	Applicable cost as noted above for generic or brand drugs	Applicable cost as noted above for generic or brand drugs	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% <u>coinsurance</u>	None
	Physician/surgeon fees	\$50 <u>copay/visit, deductible</u> doesn't apply	20% <u>coinsurance</u> after \$50 <u>copay/visit</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>copay/visit, deductible</u> doesn't apply	\$200 <u>copay/visit, deductible</u> doesn't apply	Out-of-network emergency use paid the same as in-network.
	<u>Emergency medical transportation</u>	\$200 <u>copay/visit, deductible</u> doesn't apply	\$200 <u>copay/visit, deductible</u> doesn't apply	Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	\$15 <u>copay/visit, deductible</u> doesn't apply	20% <u>coinsurance</u> after \$15 <u>copay/visit</u>	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 <u>copay/day</u> first 5 days per stay, <u>deductible</u> doesn't apply; no charge thereafter	20% <u>coinsurance</u> after \$100 <u>copay/day</u> first 5 days per stay; 20% <u>coinsurance</u> thereafter	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.

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 mental health, behavioral health, or substance abuse services	Physician/surgeon fees	No charge	20% <u>coinsurance</u>	None
	Outpatient services	Office & other outpatient services: no charge	Office & other outpatient services: 20% <u>coinsurance</u> after \$15 <u>copay/visit</u>	None
	Inpatient services	\$100 <u>copay/day</u> first 5 days per stay, <u>deductible</u> doesn't apply; no charge thereafter	20% <u>coinsurance</u> after \$100 <u>copay/day</u> first 5 days per stay; 20% <u>coinsurance</u> thereafter	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If you are pregnant	Office visits	No charge	20% <u>coinsurance</u>	Cost sharing 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 \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
	Childbirth/delivery professional services	No charge	20% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$100 <u>copay/day</u> first 5 days per stay, <u>deductible</u> doesn't apply; no charge thereafter	20% <u>coinsurance</u> after \$100 <u>copay/day</u> first 5 days per stay; 20% <u>coinsurance</u> thereafter	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	20% <u>coinsurance</u>	130 visits/calender year. Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Rehabilitation services</u>	\$15 <u>copay/visit</u> , <u>deductible</u> doesn't apply	20% <u>coinsurance</u> after \$15 <u>copay/visit</u>	60 visits/calender year for Physical, Occupational & Speech Therapy combined.
	<u>Habilitation services</u>	\$15 <u>copay/visit</u> , <u>deductible</u> doesn't apply	20% <u>coinsurance</u> after \$15 <u>copay/visit</u>	None
	<u>Skilled nursing care</u>	No charge	20% <u>coinsurance</u>	60 days/calender year. Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.

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>Durable medical equipment</u>	No charge	50% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	No charge	20% <u>coinsurance</u>	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If your child needs dental or eye care	Children's eye exam	\$15 <u>copay/visit</u> , <u>deductible</u> doesn't apply	\$15 <u>copay/visit</u> , <u>deductible</u> doesn't apply	1 routine eye exam/12 months.
	Children's glasses	No charge	No charge	\$600 maximum/12 months.
	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.)

- Dental care (Adult & Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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 - 20 visits/calender year for disease, injury & chronic pain.
- Bariatric surgery - Limited to in-network providers.
- Chiropractic care - 20 visits/calender year.
- Cosmetic surgery - Limited coverage, see policy document or call number on your ID card.
- Infertility treatment – Limited to the diagnosis & treatment of underlying medical condition
- Routine eye care (Adult) - 1 routine eye exam/12 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 1-800-370-4526.
- 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 overall deductible</u>	\$0
■ <u>Specialist copayment</u>	\$15
■ <u>Hospital (facility) copayment</u>	\$100
■ <u>Other copayment</u>	\$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	\$12,700
---------------------------	-----------------

In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$260

Managing Joe's Type 2 Diabetes

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

■ The <u>plan's overall deductible</u>	\$0
■ <u>Specialist copayment</u>	\$15
■ <u>Hospital (facility) copayment</u>	\$100
■ <u>Other copayment</u>	\$0

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:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$600
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$620

Mia's Simple Fracture

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

■ The <u>plan's overall deductible</u>	\$0
■ <u>Specialist copayment</u>	\$15
■ <u>Hospital (facility) copayment</u>	\$100
■ <u>Other copayment</u>	\$0

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>	\$0
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$300

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

307823-662695-250050

Page 8 of 8

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.

Albanian -	Për shërbime përkthimi falas për ju, telefononi 1-800-370-4526.
Amharic -	የኢትዮጵያ አገልግሎትና የለከናዸ ለማግኘት በ 1-800-370-4526 ይደምላል::
Arabic -	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء التصال على الرقم 1-800-370-4526
Armenian -	Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-800-370-4526 հեռախոսահամարով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.
Bantu-Kirundi -	Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-800-370-4526.
Bengali-Bangala -	আপনাকে বিনামূলক ভাষা পরিকল্পনা প্রক্রিয়া প্রস্তুত কর্তব্য এই নথিক প্রেরণ করা হচ্ছে। আপনাকে বিনামূলক ভাষা পরিকল্পনা প্রক্রিয়া প্রস্তুত কর্তব্য এই নথিক প্রেরণ করা হচ্ছে। 1-888-982-386।
Bisayan-Visayan -	Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-800-370-4526.
Burmese -	သင့်အော်မျဖို့ အခေါ်ကူးပေါ်မေးရပဲ ဘာသာစကားဝန်ဝေဆိုမှုး ရရှိုံးပိုင် 1-800-370-4526 သို့ပုံနှံးပေးခေါ်ခြင်ပါ။
Catalan -	Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-800-370-4526.
Chamorro -	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-800-370-4526.
Cherokee -	GYAHSAHOMA OGOTHESOLAL L AGOMA JGEGWALI NY, OGITHWOB 1-800-370-4526.
Chinese -	如欲使用免費語言服務，請致電 1-800-370-4526.
Choctaw -	Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-800-370-4526.
Cushite -	Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-800-370-4526.
Dutch -	Voor gratis toegang tot taaldiensten, bell 1-800-370-4526.
French -	Afin d'accéder aux services langagiers sans frais, composez le 1-800-370-4526.
French Creole -	Pou jwenn sèvis lang gratis, rele 1-800-370-4526.
German -	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 -	તમારેકોઇ જાતના ખર્ચવિના ભાષાની સેંચાઓની પહોર માટે, કોલ કરો 1-800-370-4526.

Hawaiian -	No ka wala‘au ‘ana me ka lawelawe ‘ōlelo e kahea aku i kēia helu kelepona 1-800-370-4526. Kāki ‘ole ‘ia kēia kōkua nei.
Hindi -	आपकेलिए बिना कक्सी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए, 1-800-370-4526 पर कॉल करें।
Hmong -	Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-800-370-4526.
Igbo -	Iji nwetaòhèrè na ọru gasị asusụ n'efu, kpọọ 1-800-370-4526
Ilocano -	Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-800-370-4526.
Indonesian -	Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-800-370-4526.
Italian -	Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-800-370-4526.
Japanese -	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 -	လာတိုကဗုဏ်ကိုပြုအတိုက်မှတ်အတိုးတိုးမှတ်ဖုန်းတိုးအပြုလာကဘာ့ဟန်အိုအိုကို ကို 1-800-370-4526 တကူး။
Korean -	무료 언어 서비스를 이용하려면 1-800-370-4526 번으로 전화해 주십시오.
Kru-Bassa -	Miller diyi wuqu-dù kà kò dò bë dyi móú nì Pídyi ní, nií, dà nòbà nià ke: 1-800-370-4526
Kurdish -	بۆ دەسپیئر اگەيشتن بە خزمەتكۆز ارى زمان بەسى تىچۇون بۆ تو، پەپوەندى بىھ بە ژمارەى 1-800-370-4526
Laotian -	ເພື່ອຂັ້ນໃຈກໍານົມວິການພາກສາໄດ້ລັບເນັດລົກ່າກັບທ່ານ, ໃຫ້້ທ່ານເປີ 1-888-982-3862
Marathi -	कोणत्याही शलुकालशवाय भाषा सेवा प्राप्त करण्यासाठी,, 1-800-370-4526 वर फोन करा.
Marshallese -	Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-800-370-4526.
Micronesian- Pohnpeyan -	Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-800-370-4526.
Mon-Khmer, Cambodian -	ເជີ່ມື້ອົກສອນດາວໂຫຼວດເສດຖະກິດຂາສາເຈີດລະຕິຕິດໃໝ່ສປາປ່ານມູນ ສູມເຫດໄຟຮັດຕູກ້າວັນ 1-888-982-3862
Navajo -	T'áá ni nizaad k'ehjí bee níká a'doowoł doo báqh ilínígóó koji' hólne' 1-800-370-4526.
Nepali -	निःशुल्क भाषा सेवा प्राप्त गर्ने 1-800-370-4526 मा टेलिफोन गर्नुहोस् ।
Nilotic-Dinka -	Të koor yin wëëř de thokic ke cïn wëu kör keek tënöŋ yin. Ke cöl koc ye koc kuony ne nomba 1-800-370-4526.
Norwegian -	For tilgang til kostnadsfri språktjenester, ring 1-800-370-4526.
Pennsylvania Dutch -	Um Schprooch Services zu griege mitaus Koscht, ruff 1-800-370-4526.
Persian -	برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-800-370-4526 تماس بگیرید.
Polish -	Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-800-370-4526.
Portuguese -	Para acessar os serviços de idiomas sem custo para você, ligue para 1-800-370-4526.

Punjabi -	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-800-370-4526 'ਤੇ ਛੋਨ ਕਰੋ।
Romanian -	Pentru a accesa gratuit serviciile de limbă, apelați 1-800-370-4526.
Russian -	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-800-370-4526.
Samoan -	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.
Sudanic-Fulfude -	Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-800-370-4526.
Swahili -	Kupata huduma za lugha bila malipo kwako, piga 1-800-370-4526.
Syriac -	جَلْ يَلْجِيَّنْ رَهْبَنْكَهْ حَلْقَنْ خَتَنْبَهْ، صَبَحَهْ : ۱-۸۰۰-۳۷۰-۴۵۲۶
Tagalog -	Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-800-370-4526.
Telugu -	మీరు భాష సేవలను ఉచితంగా అందుకున్నందుకు, 1-800-370-4526 కు కాల్ చేయండి.
Thai -	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-800-370-4526.
Tongan -	Kapau 'oku ke fiema'u ta'etōtōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-800-370-4526.
Trukese -	Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-800-370-4526.
Turkish -	Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-800-370-4526 numarayı arayın.
Ukrainian -	Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-800-370-4526.
Urdu -	بالقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے، 1-888-982-3862 پر بات کریں۔
Vietnamese -	Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-800-370-4526.
Yiddish -	צֹו צוֹטְרִיט שְׁפָרָאָר בָּאָדִינוֹנְגָעָן אַיִן קִיִּין פֿרִיז צֹו אַיִר, רּוֹפָן
Yoruba -	Lati wọnú awọn isé èdè l'ofe fun ọ, pe 1-800-370-4526.