Coverage for: Individual + Family | Plan Type: EPO



The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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, <u>www.HealthReformPlanSBC.com</u> or by calling 1-800-370-4526. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> 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<br><u>deductible</u> ?                                | \$0.   | See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.   |
| Are there services covered<br>before you meet your<br><u>deductible</u> ? | No.  | You will have to meet the <u>deductible</u> before the <u>plan</u> pays for any services   |
| Are there other <u>deductibles</u> for specific services?                 | No.  | You don't have to meet deductibles for specific services.  |
| What is the <u>out-of-pocket</u><br><u>limit</u> for this <u>plan</u> ?   | In- <u>Network</u> : Individual \$5,480 / Family \$10,960.<br>Rx: Individual \$1,580 / Family \$3,160.                 | 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</u> <u>limits</u> until the overall family <u>out–of–pocket limit</u> has been met.   |
| What is not included in the<br><u>out-of-pocket limit</u> ?               | Premiums, balance-billing charges & health care this plan 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<br><u>network provider</u> ?               | Yes. See http://www.aetna.com/docfind or call<br>1-855-223-8791 for a list of in- <u>network</u><br><u>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</u> <u>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<br>a <u>specialist</u> ?             | No.  | You can see the <u>specialist</u> you choose without a <u>referral</u> .   |



All **<u>copayment</u>** and **<u>coinsurance</u>** costs shown in this chart are after your **<u>deductible</u>** has been met, if a **<u>deductible</u>** applies.

| Common Medical<br>Event  | Services You May Need   | What You<br>In-Network<br>Provider<br>(You will pay the<br>least)          | u Will Pay<br>Out-of-Network<br>Provider<br>(You will pay the<br>most) | Limitations, Exceptions, & Other Important<br>Information  |
|--|---|--|--|--|
| If you visit a health<br>care <u>provider</u> 's   | Primary care visit to treat an injury or illness<br><u>Specialist</u> visit | \$20 <u>copay</u> /visit<br>\$20 <u>copay</u> /visit                       | Not covered<br>Not covered   | None<br>None<br>You may have to pay for services that aren't   |
| office or clinic   | Preventive care /screening /immunization                                    | No charge  | Not covered  | preventive. Ask your <u>provider</u> if the services<br>needed are preventive. Then check what your<br><u>plan</u> will pay for.   |
| If you have a test   | Diagnostic test (x-ray, blood work)   | No charge  | Not covered  | None   |
| ·· <b>,</b> · · · · · · · · · · · · · · · · · · ·  | Imaging (CT/PET scans, MRIs)  | No charge  | Not covered  | None   |
| If you need drugs<br>to treat your<br>illness or   | Generic drugs   | \$0 copay/ retail<br>prescription and<br>\$0/prescription mail<br>order    | \$0 copay + 20%<br>coinsurance/ retail<br>prescription                 | Covers up to a 90-day supply (retail prescription);<br>31-90-day supply (mail order prescription) Your<br>plan uses a preferred drug list which identifies<br>the status of covered drugs. Some drugs may<br>require preauthorization, if the necessary<br>preauthorization is not obtained, the drug may<br>not be covered. |
| condition<br>More information<br>about <u>prescription</u><br><u>drug coverage</u> is<br>available at<br><u>www.expresscripts.</u> | Preferred brand drugs   | \$20 copay/ retail<br>prescription and<br>\$20/ prescription<br>mail order | \$20 copay + 20%<br>coinsurance/ retail<br>prescription                | Covers up to a 90-day supply (retail prescription);<br>31-90-day supply (mail order prescription) Your<br>plan uses a preferred drug list which identifies<br>the status of covered drugs. Some drugs may<br>require preauthorization, if the necessary<br>preauthorization is not obtained, the drug may<br>not be covered. |
| com  | Non-preferred brand drugs   | \$20 copay/ retail<br>prescription and<br>\$20/prescription<br>mail order  | \$20 copay + 20%<br>coinsurance / retail<br>prescription               | Covers up to a 90-day supply (retail prescription);<br>31-90-day supply (mail order prescription) Your<br>plan uses a preferred drug list which identifies<br>the status of covered drugs. Some drugs may<br>require preauthorization, if the necessary<br>preauthorization is not obtained, the drug may<br>not be covered. |

|   | What You Will Pay                              |  |  |   |
|---|--|--|--|---|
| Common Medical<br>Event   | Services You May Need                          | In-Network<br>Provider<br>(You will pay the<br>least)  | Out-of-Network<br>Provider<br>(You will pay the<br>most) | Limitations, Exceptions, & Other Important<br>Information   |
|   | Specialty drugs                                | \$0 copay or \$20<br>copay (contingent<br>upon tier) / retail<br>prescription or mail<br>order | Not covered  | Covers up to a 90-day supply (retail prescription);<br>31-90-day supply (mail order prescription)   |
| If you have   | Facility fee (e.g., ambulatory surgery center) | No charge  | Not covered  | None  |
| outpatient surgery  | Physician/surgeon fees                         | No charge  | Not covered  | None  |
|   | Emergency room care                            | \$100 <u>copay</u> /visit  | \$100 <u>copay</u> /visit                                | Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . No coverage for non-emergency use.                                       |
| If you need<br>immediate medical<br>attention                             | Emergency medical transportation               | No charge  | No charge  | Out-of- <u>network</u> emergency use paid the same as<br>in- <u>network</u> . Non-emergency transport: not<br>covered, except<br>if pre-authorized. |
|   | <u>Urgent care</u>                             | \$20 <u>copay</u> /visit   | Not covered  | No coverage for non-urgent use.   |
| If you have a   | Facility fee (e.g., hospital room)             | No charge  | Not covered  | None  |
| hospital stay   | Physician/surgeon fees                         | No charge  | Not covered  | None  |
| If you need mental<br>health, behavioral<br>health, or<br>substance abuse | Outpatient services                            | Office: \$20<br><u>copav</u> /visit; other<br>outpatient services:<br>no charge                | Not covered  | None  |
| services  | Inpatient services                             | No charge  | Not covered  | None  |
|   | Office visits                                  | No charge  | Not covered  | Cost sharing does not apply for preventive  |
| If you are pregnant   | Childbirth/delivery professional services      | No charge  | Not covered  | services. Maternity care may include tests and  |
|   | Childbirth/delivery facility services          | No charge  | Not covered  | services described elsewhere in the SBC (i.e., ultrasound.)   |
|   | Home health care                               | No charge  | Not covered  | None  |
| If you need help<br>recovering or have                                    | Rehabilitation services                        | \$20 <u>copay</u> /visit   | Not covered  | 60 visits/calendar year for Physical, Occupational & Speech Therapy combined.   |
| other special<br>health needs   | Habilitation services                          | No charge  | Not covered  | None  |
|   | Skilled nursing care                           | No charge  | Not covered  | 120 days/calendar year.   |

| Common Medical<br>Event                | Services You May Need      | What You<br>In-Network<br>Provider<br>(You will pay the<br>least) | u Will Pay<br>Out-of-Network<br>Provider<br>(You will pay the<br>most) | Limitations, Exceptions, & Other Important<br>Information  |
|--|----------------------------|---|--|--|
|  | Durable medical equipment  | No charge   | Not covered  | Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse. |
|  | Hospice services           | No charge   | Not covered  | None   |
| If your shild peeds                    | Children's eye exam        | No charge   | Not covered  | 1 routine eye exam/24 months.  |
| If your child needs dental or eye care | 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.)

• Cosmetic surgery

Glasses (Child)

.

Dental care (Adult & Child)

- Long-term care
  - Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs Except for required <u>preventive</u> services.

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

| <ul> <li>Acupuncture - 10 visits/calendar year for<br/>disease, injury &amp; chronic pain</li> <li>Bariatric surgery</li> <li>Chiropractic care - 20 visits/calendar year.</li> </ul> | <ul> <li>Hearing aids - 1 hearing aid to \$1,000<br/>maximum per ear/24 months for children up<br/>to age 16.</li> <li>Infertility treatment - For more information &amp;<br/>exceptions, see policy document provided by<br/>your employer or call the number on your ID<br/>card.</li> </ul> | <ul> <li>Private-duty nursing - Included as part of <u>home health care</u>.</li> <li>Routine eye care (Adult) - 1 routine eye exam/24 months.</li> </ul> |
|---|--|---|
|---|--|---|

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 <a href="http://www.dol/gov/ebsa/healthreform">http://www.dol/gov/ebsa/healthreform</a>

- 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 <u>plan</u>, church <u>plans</u> 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 <u>Health Insurance Marketplace</u>. For more information about the <u>Marketplace</u>, visit <u>www.HealthCare.gov</u> 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 <a href="http://www.dol/gov/ebsa/healthreform">http://www.dol/gov/ebsa/healthreform</a>
- 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 <u>www.cciio.cms.gov</u>.
- Additionally, a consumer assistance program can help you file your <u>appeal</u>. Contact information is at: <u>http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html</u>.

### Does this plan provide Minimum Essential Coverage? Yes.

<u>Minimum Essential Coverage</u> generally includes <u>plans</u>, <u>health insurance</u> available through the <u>Marketplace</u> or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of <u>Minimum Essential Coverage</u>, you may not be eligible for the <u>premium tax credit</u>.

## 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 <u>plan</u> might cover costs for a sample medical situation, see the next section



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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)                           |

\$0

\$20

\$0

\$0

| The <u>plan's</u> overall <u>deductible</u> |  |
|---|--|
| Specialist copayment                        |  |
| Hospital (facility) <u>copayment</u>        |  |
| Other <u>copayment</u>                      |  |

This EXAMPLE event includes services like:Specialistoffice visits (prenatal care)Childbirth/DeliveryProfessional ServicesChildbirth/DeliveryFacility ServicesDiagnostic tests(ultrasounds and blood work)Specialistvisit (anesthesia)

| Total Example Cost              | \$12,700 |
|---------------------------------|----------|
| In this example, Peg would pay: |          |
| <u>Cost Sharing</u>             |          |
| <u>Deductibles</u>              | \$0      |
| <u>Copayments</u>               | \$0      |
| <u>Coinsurance</u>              | \$0      |
| What isn't covered              |          |
| Limits or exclusions            | \$70     |
| The total Peg would pay is      | \$70     |

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

| The <u>plan's</u> overall <u>deductible</u> | \$0  |
|---|------|
| Specialist copayment                        | \$20 |
| Hospital (facility) <u>copayment</u>        | \$0  |
| Other <u>copayment</u>                      | \$0  |

This EXAMPLE event includes services like:Primary care physicianoffice visits (includingdisease education)Diagnostic tests (blood work)Prescription drugsDurable 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>               | \$200   |  |
| Coinsurance                     | \$0     |  |
| What isn't covered              |         |  |
| Limits or exclusions            | \$4,300 |  |
| The total Joe would pay is      | \$4,500 |  |

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

| The <u>plan's</u> overall <u>deductible</u> | \$0  |
|---|------|
| Specialist copayment                        | \$20 |
| Hospital (facility) <u>copayment</u>        | \$0  |
| Other <u>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: |         |  |
| Cost Sharing                    |         |  |
| Deductibles                     | \$0     |  |
| <u>Copayments</u>               | \$200   |  |
| Coinsurance                     | \$0     |  |
| What isn't covered              |         |  |
| Limits or exclusions            | \$10    |  |
| The total Mia would pay is      | \$210   |  |

#### **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 <a href="https://ocrportal.hhs.gov/ocr/portal/lobby.jsf">https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</a>, 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).

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## 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 -          | የቋንቋ አንልግሎቶችን ያለክፍያ ለማግኘት፣ በ ו-800-370-4526 ይደውሉ።  |
| Arabic -           | للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء االتصال على الرقم 4526-370-1800  |
| Armenian -         | Անվձար 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 বিনামূকযে ভাষা পবিকষিা পপকে হকয এই নম্বকি পেবযক ান েরুন: 1-888-982-386।   |
| Bisayan-Visayan -  | Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-800-370-4526.  |
| Burmese -          | သင့္အေနျဖင့္ အခေၾကးေငြ မေပးရပဲ ဘာသာစကားဝန္ေဆာင္မႈမ်ား ရရွိႏုိင္ရန္ 1-800-370-4526 သို႕ ဖုန္းေခၚဆုိပါ။                          |
| 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 -         | GУ๗҄҄ ⅄ ՏಲћѦ๗҄҄҄҄҄҄ А Ѻ҄GѲ҄ҍѻ҄҄ЛѦ Ĺ ѦГѻ҄Ѧ ѦGEGѠӅѦ љУ, ҨҎѦҌѠѻ҄Ъ 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<br>1-800-370-4526. |
| Gujarati -         | તમારેકોઇ જાતના ખર્ચવિના ભાષાની સેિાઓની પહોોંર્ માટે, કોલ કરો1-800-370-4526.  |

| 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 ककसी 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.   |
| lgbo -                        | lji nwetaòhèrè na ọrụ gasi asụsụ n'efu, kpọọ 1-800-370-4526   |
| llocano -                     | 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 -                       | လၢတၢ်ကမၤန္နာ်ကိုဉ်အတၢ်မၢစၢၤအတၢ်ဖံးတၢ်မၢတဖဉ်လၢတအိဉ်ဒီးအပ္ဒၤလၢကဘာ်ဟ့ဉ်အီၤအဂ်ိၢဘာ်နှဉ် ကိႊ 1-800-370-4526 တက္ၢ်            |
| Korean -                      | 무료 언어 서비스를 이용하려면 1-800-370-4526 번으로 전화해 주십시오.   |
| Kru-Bassa -                   | Μ dyi wuqu-dù kà kò qò ɓĕ dyi mɔú ń nì Pídyi ní, nìí, qá nɔ̀ɓà nìà kɛ: 1-800-370-4526                                   |
| Kurdish -                     | بۆ دەسپێړاگەيشتن بە خزمەتگوزارى زمان بەبـێ نێچوون بۆ نۆ، پەيوەندى بكە بە ژمارەي 4526-370-800-1                          |
| Laotian -                     | ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ1-888-982-3862   |
| Marathi -                     | कोणत्याही शल्ुकालशवाय भाषा सेवा प्राप्त करण्यासाठी,, 1-800-370-4526 वर फोन करा.   |
| Marshallese -<br>Micronesian- | Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-800-370-4526.                                |
| Pohnpeyan -                   | Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-800-370-4526.   |
| Mon-Khmer,<br>Cambodian -     | ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-888- 982-3862។                             |
| Navajo -                      | T'áá ni nizaad k'ehjí bee níká a'doowoł doo bą́ą́h ílínígóó kojį' hólne' 1-800-370-4526.                                |
| Nepali -                      | निःशुल्क भाषा सेवा प्राप्त गर्न 1-800-370-4526 मा टेलिफोन गर्नुहोस् ।   |
| Nilotic-Dinka -               | Të koor yïn weër de thokic ke cïn wëu kor keek tënon yïn. Ke col 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 4526-370-400 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 ਵਾਲੀਆ।ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-800-370-4526 'ਤੇ ਫ਼ੋਨ 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 -          | :رمحبته، ملبحت، جلعته، جل بيلجلي، المنبغة، جلعته، عديدة، معديقة، من العنه، عن العنه، من العنه، عن الع             |
| Tagalog -         | Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-800-370-4526.                    |
| Telugu -          | మీరు భాష సేవలను ఉచితంగా అందుకునందుకు, 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 ، 3862-982-888-1 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 -         | 1-800-370-4526 צו צוטריט שפרַאך בַאדינונגען אין קיין פרייַז צו איר, רופן  |
| Yoruba -          | Lati wọnú awọn isẹ èdè l'ọfẹ fun ọ, pe 1-800-370-4526.  |
|                   |   |