Coverage for: EE Only; EE+ 1 or more | Plan Type: POS



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 1-866-276-5125. 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 underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-866-276-5125 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	In- <u>Network</u> : EE Only \$1,600; EE+ 1 or more \$3,200. Out-of-Network: EE Only \$3,200; EE+ 1 or more \$6,400 Amount your employer contributes to your account (HRA): Up to <b>\$500</b> /individual or \$ <b>1,000</b> /family	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 policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay. A Health Reimbursement Arrangement (HRA) is available that works with your medical <u>plan</u> , as described in your employer's Summary Plan Description.
Are there services covered before you meet your <u>deductible</u> ?	Yes. In- <u>network preventive care</u> is 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 <u>https://www.healthcare.gov/coverage/preventive-care-benefits/</u>
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> <u>limit</u> for this <u>plan</u> ?	In- <u>Network</u> : EE Only \$3,200; EE+ 1 or more \$6,400. Out-of-Network: EE Only \$6,400; EE+ 1 or more \$12,800.	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> , the overall family <u>out–of–pocket limit</u> must be met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premium</u> s, <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover & penalties for failure to obtain <u>pre-authorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out–of–pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <u>www.aetna.com/docfind</u> or call 1-866- 276-5125 for a list of in- <u>network providers</u> .	This <u>plan</u> uses a <u>provider</u> <u>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 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.

	What You Will Pay					
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information		
If you visit a health care <u>provider</u> 's office or clinic	Primary care visit to treat an injury or illness <u>Specialist</u> visit <u>Preventive care</u> /screening /immunization	20% <u>coinsurance</u> 20% <u>coinsurance</u> No charge	40% <u>coinsurance</u> 40% <u>coinsurance</u> 40% <u>coinsurance</u> , except no charge	None None You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services		
If you have a test	Diagnostic test (x-ray, blood work) Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u> 20% coinsurance	for immunizations 40% <u>coinsurance</u> 40% coinsurance	needed are preventive. Then check what your <u>plan</u> will pay for. None None		
If you need drugs	Generic drugs	<u>Copay</u> /prescription: 20% (retail & mail order)	20% <u>coinsurance</u> after <u>copay</u> / prescription: 20% (retail)	Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral fertility drugs. No charge for preferred generic FDA-		
to treat your illness or condition More information	Preferred brand drugs	<u>Copav</u> /prescription: 20% (retail & mail order)	20% <u>coinsurance</u> after <u>copay</u> / prescription: 20% (retail)	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 unless		
about <u>prescription</u> <u>drug coverage</u> is available at <u>www.aetnapharmac</u> <u>y.com/advancedcon</u> <u>trol</u>	Non-preferred brand drugs	<u>Copay</u> /prescription: 20% (retail & mail order)	20% <u>coinsurance</u> after <u>copav</u> / prescription: 20% (retail)	prescribed Dispense as Written; cost difference penalty doesn't apply to <u>deductible</u> or <u>out-of-</u> <u>pocket limit</u> . Maintenance drugs- after two retail fills, members are required to fill a 90-day supply at CVS Caremark® Mail Service Pharmacy or CVS Pharmacy. <u>Deductible</u> doesn't apply to certain preventive medications.		
	Specialty drugs	Applicable cost as noted above for generic or brand drugs	Not covered	All prescriptions must be filled through the Aetna Specialty Performance Pharmacy <u>Network</u> . Precertification required for coverage.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% coinsurance	None		
outpatient surgery	Physician/surgeon fees	20% coinsurance	40% coinsurance	None		

	What You Will Pay				
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Emergency room care	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . No coverage for non-emergency use.	
If you need immediate medical attention	Emergency medical transportation	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . Non-emergency transport: not covered, except if pre-authorized.	
	<u>Urgent care</u>	20% <u>coinsurance</u>	20% coinsurance	No coverage for non-urgent use.	
lf you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Penalty of \$750 for failure to obtain <u>pre-</u> <u>authorization</u> for out-of-network care.	
nospilai slay	Physician/surgeon fees	20% <u>coinsurance</u>	40% coinsurance	None	
If you need mental health, behavioral health, or	Outpatient services	Office & other outpatient services: 20% <u>coinsurance</u>	Office & other outpatient services: 40% <u>coinsurance</u>	None	
substance abuse services	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Penalty of \$750 for failure to obtain <u>pre-</u> authorization for out-of-network care.	
	Office visits	No charge	40% coinsurance	Cost sharing does not apply for preventive	
If you are pregnant	Childbirth/delivery professional services Childbirth/delivery facility services	20% <u>coinsurance</u> 20% <u>coinsurance</u>	40% <u>coinsurance</u> 40% <u>coinsurance</u>	<u>services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Penalty of \$750 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.	
	Home health care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	120 visits/calendar year combined with private- duty nursing. Penalty of \$750 for failure to obtain pre-authorization for out-of-network care.	
lf you need help	Rehabilitation services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	90 visits/calendar year for Physical, Occupational, Speech & Cognitive Therapy combined, including outpatient hospital services.	
recovering or have other special	Habilitation services	20% coinsurance	40% coinsurance	None	
health needs	Skilled nursing care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	90 days/calendar year. Penalty of \$750 for failure to obtain <u>pre-authorization</u> for out-of-network care.	
	Durable medical equipment	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.	

Common Medical Event	Services You May Need	What You In-Network Provider (You will pay the least)	u Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Hospice services	0% <u>coinsurance</u>	40% <u>coinsurance</u>	Penalty of \$750 for failure to obtain <u>pre-</u> authorization for out-of-network care.	
If your child needs	Children's eye exam Children's glasses	Not covered Not covered	Not covered Not covered	Not covered. Not covered.	
dental or eye care	Children's dental check-up	Not covered	Not covered	Not covered.	

# **Excluded Services & Other Covered Services:**

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

<ul> <li>Bariatric surgery</li> <li>Glasses (Child)</li> <li>Cosmetic surgery</li> <li>Dental care (Adult &amp; Child)</li> <li>Non-emergency care when traveling outside the U.S.</li> <li>Routine eye care (Adult &amp; Child)</li> <li>Routine foot care</li> <li>Weight loss programs - Except for required preventive services.</li> </ul>	<u>/e</u>
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### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

•	Acupuncture - 20 visits/calendar year for	•	Hearing aids - \$3,000 maximum/24 months.	٠	Private-duty nursing - Included as part of home health care.
	disease, injury & chronic pain.	٠	Infertility treatment - Limited to the diagnosis		
•	Chiropractic care - 20 visits/calendar year.		& treatment of underlying medical condition.		

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 <u>plan</u> at 1-866-276-5125.
- 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 <u>www.cciio.cms.gov</u>.
- 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

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your plan documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. 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 1-866-276-5125. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <u>http://www.dol/gov/ebsa/healthreform</u>
- For non-federal governmental group health <u>plans</u>, 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.

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 <u>plan</u> 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 <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)

The plan's overall deductible	\$1,600
Specialist coinsurance	20%
Hospital (facility) <u>coinsurance</u>	20%
Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like: <u>Specialist</u> office visits (*prenatal care*) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (*ultrasounds and blood work*) <u>Specialist</u> visit (*anesthesia*)

Total Example Cost	\$12,700
In this example, Peg would pay:	
<u>Cost Sharing</u>	
Deductibles	\$1,600
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,600
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,260

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>	\$1,600
Specialist coinsurance	20%
Hospital (facility) <u>coinsurance</u>	20%
Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like: <u>Primary care physician</u> office visits (including disease education) <u>Diagnostic tests</u> (blood work) <u>Prescription drugs</u> <u>Diabetic supplies</u> (glucose meter)

Total Example Cost	\$5,600
In this example, Joe would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,600
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$800
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$2,420

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

The <u>plan's</u> overall <u>deductible</u>	\$1,600
Specialist coinsurance	20%
Hospital (facility) <u>coinsurance</u>	20%
Other <u>coinsurance</u>	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>			
Deductibles	\$1,600		
<u>Copayments</u>	\$0		
<u>Coinsurance</u>	\$200		
What isn't covered			
Limits or exclusions	\$0		
The total Mia would pay is	\$1,800		

#### **Assistive Technology**

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-866-276-5125.

#### **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).

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 1-866-276-5125.

Albanian -	Për shërbime përkthimi falas për ju, telefononi 1-866-276-5125.
Amharic -	የቋንቋ አንልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-866-276-5125 ይደውሉ፡፡
Arabic -	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء االتصال على الرقم 5125-276-1866
Armenian -	ԱնվՃար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-866-276-5125 հեռախոսահամարով։
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-866-276-5125 tanpa dikenakan biaya.
Bantu-Kirundi -	Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-866-276-5125.
Bengali-Bangala -	আপনাকে বিনামূকযে ভাষা পবিকষিা পপকে হকয এই নম্বকি পেবযক ান েরুন: 1-888-982-3861
Bisayan-Visayan -	Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-866-276-5125.
Burmese -	သင့္အေနျဖင့္ အခေၾကးေငြ မေပးရပဲ ဘာသာစကားဝန္ေဆာင္မႈမ်ား ရရွိႏုိင္ရန္ 1-866-276-5125 သို႕ ဖုန္းေခၚဆုိပါ။
Catalan -	Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-866-276-5125.
Chamorro -	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-866-276-5125.
Cherokee -	GУФЛ ՏಲհАФЛ ФСӨЬСЛЛ Ը АГФЛ ЛСЕGWЛЛ ЉУ, ФРАЬWСЪ 1-866-276-5125.
Chinese -	如欲使用免費語言服務,請致電 1-866-276-5125.
Choctaw -	Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-866-276-5125.
Cushite -	Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-866-276-5125.
Dutch -	Voor gratis toegang tot taaldiensten, bell 1-866-276-5125.
French -	Afin d'accéder aux services langagiers sans frais, composez le 1-866-276-5125.
French Creole -	Pou jwenn sèvis lang gratis, rele 1-866-276-5125.
German -	Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-866-276-5125 an.
Greek -	Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-866-276-5125.
Gujarati -	તમારેકોઇ જાતના ખર્ચવિના ભાષાની સેિાઓની પહોોંર્ માટે, કોલ કરો1-866-276-5125.

Hawaiian -	No ka wala'au 'ana me ka lawelawe 'ōlelo e kahea aku i kēia helu kelepona 1-866-276-5125. Kāki 'ole 'ia kēia kōkua nei.
Hindi -	आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए,1-866-276-5125 पर कॉल करें।
Hmong -	Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-866-276-5125.
lgbo -	lji nwetaòhèrè na ọrụ gasi asụsụ n'efu, kpọọ 1-866-276-5125
llocano -	Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-866-276-5125.
Indonesian -	Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-866-276-5125.
Italian -	Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-866-276-5125.
Japanese -	言語サービスを無料でご利用いただくには、1-866-276-5125 までお電話ください。
Karen -	လ၊တါကမၤန္နါကို်ဝ်အတါမၢစၢၤအတၢ်ဖံးတါမ၊တဖဉ်လ၊တအိဉ်ဒီးအမှုၤလ၊ကဘဉ်ဟ့ဉ်အီၤအဂ်ီ၊ဘဉ်နှဉ် ကိး 1-866-276-5125တက္။
Korean -	무료 언어 서비스를 이용하려면 1-866-276-5125 번으로 전화해 주십시오.
Kru-Bassa -	Μ dyi wuqu-dù kà kò qò ɓĕ dyi mɔú ń nì Pídyi ní, nìí, qá nɔ̀ɓà nìà kɛ: 1-866-276-5125
Kurdish -	بۆ دەسپێڕاگەيشتن بە خزمەتگوزارى زمان بەبىێ نێچوون بۆ نۆ، پەيوەندى بكە بە ژمارەي 5125-276-866-1
Laotian -	ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ1-888-982-3862
Marathi -	कोणत्याही शल्ुकालशवाय भाषा सेवा प्राप्त करण्यासाठी,, 1-866-276-5125 वर फोन करा.
Marshallese - Micronesian-	Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-866-276-5125.
Pohnpeyan -	Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-866-276-5125.
Mon-Khmer, Cambodian -	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-888- 982-3862។
Navajo -	T'áá ni nizaad k'ehjí bee níká a'doowoł doo bą́ą́h ílínígóó kojį' hólne' 1-866-276-5125.
Nepali -	निःशुल्क भाषा सेवा प्राप्त गर्न 1-866-276-5125 मा टेलिफोन गर्नुहोस् ।
Nilotic-Dinka -	Të koor yïn wɛɛ̈r de thokic ke cïn wëu kor keek tënoŋ yïn. Ke col koc ye koc kuony ne nomba 1-866-276-5125.
Norwegian -	For tilgang til kostnadsfri språktjenester, ring 1-866-276-5125.
Pennsylvania Dutch -	Um Schprooch Services zu griege mitaus Koscht, ruff 1-866-276-5125.
Persian -	بر ای دسترسی به خدمات زبان به طور رایگان، با شماره 5125-276-866 تماس بگیرید .
Polish -	Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-866-276-5125.
Portuguese -	Para acessar os serviços de idiomas sem custo para você, ligue para 1-866-276-5125.

Punjabi -	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-866-276-5125 'ਤੇ ਫ਼ੋਨ ਕਰੋ।
Romanian -	Pentru a accesa gratuit serviciile de limbă, apelați 1-866-276-5125.
Russian -	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-866-276-5125.
Samoan -	Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-866-276-5125.
Serbo-Croatian -	Za besplatne prevodilačke usluge pozovite 1-866-276-5125.
Spanish -	Para acceder a los servicios de idiomas sin costo, llame al 1-866-276-5125.
Sudanic-Fulfude -	Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-866-276-5125.
Swahili -	Kupata huduma za lugha bila malipo kwako, piga 1-866-276-5125.
Syriac -	:رمح، ته، ملبق بخيخته جلة بن الله الله المنه منه المنه منه منه المنه منه المنه المنه المنه منه منه منه منه منه منه منه منه المنه المنه المنه منه منه منه المنه المنه منه منه منه منه منه منه منه منه منه
Tagalog -	Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-866-276-5125.
Telugu -	మీరు భాష సేవలను ఉచితంగా అందుకునందుకు, 1-866-276-5125 కు కాల్ చేయండి.
Thai -	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-866-276-5125.
Tongan -	Kapau 'oku ke fiema'u ta'etōtōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-866-276-5125.
Trukese -	Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-866-276-5125.
Turkish -	Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-866-276-5125 numarayı arayın.
Ukrainian -	Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-866-276-5125.
Urdu -	بالقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 3862-982-1888 پر بات کریں۔
Vietnamese -	Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-866-276-5125
Yiddish -	צו צוטריט שפרַאך בַאדינונגען אין קיין פרייַז צו איר, רופן 1-866-276-5125
Yoruba -	Lati wọnú awọn isẹ èdè l'ofẹ fun o, pe 1-866-276-5125.