Coverage for: Individual + Family | Plan Type:



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 <u>deductible</u> ?	\$0. Out-of-Network: Individual \$350 / Family \$700.	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. 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 <u>https://www.healthcare.gov/coverage/preventive-care-benefits/</u>
Are there other <u>deductible</u> s 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> ?	Aetna Whole Health In- <u>Network</u> : Individual \$500 / Family \$1,000. Out-of-Network: Individual \$2,000 / Family \$5,000. Prescription Drugs Separate out-of- pocket limit is Individual \$1,600 / Family \$3,200	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 <u>out-of-pocket limit</u> ?	Premiums, 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</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 Yo	u Will Pay	
Common Medical Event	Services You May Need	Aetna Whole Health In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	\$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	None
lf vou visit s basith	<u>Specialist</u> visit	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	None
If you visit a health care <u>provider</u> 's office or clinic	Preventive care /screening /immunization	No charge	Not covered, except 30% <u>coinsurance</u> for gynecological exams & mammograms; <u>deductible</u> doesn't apply to child immunizations	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	Diagnostic test (x-ray, blood work)	No charge	30% coinsurance	None
li you have a test	Imaging (CT/PET scans, MRIs)	No charge	30% <u>coinsurance</u>	None
If you need drugs	Generic drugs	\$5 retail; \$10 mail	Not covered	Up to 30-day supply at retail; 90-day mail order.
to treat your	Preferred brand drugs	\$10 retail; \$20 mail	Not covered	Step Therapy with NO Grandfathering applies. For Brand drugs with a Generic Equivalent available, member pays
illness or condition	Non-preferred brand drugs	\$10 retail; \$20 mail	Not covered	the difference in cost between generic & brand, plus brand copay.
More information about <u>prescription</u> <u>drug coverage</u> is available at www.aetna.com/pha rmacy- insurance/individual s-families	<u>Specialty drugs</u>	Same as retail	Not covered	Up to 30-day supply – must be filled through Accredo Specialty Pharmacy

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		What Yo	u Will Pay	
Common Medical Event	Services You May Need	Aetna Whole Health In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have	Facility fee (e.g., ambulatory surgery center)	No charge	30% coinsurance	None
outpatient surgery	Physician/surgeon fees	No charge	30% <u>coinsurance</u>	None
	Emergency room care	\$125 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$125 <u>copay</u> /visit, <u>deductible</u> doesn't apply	No coverage for non-emergency use.
If you need immediate medical attention	Emergency medical transportation	10% <u>coinsurance,</u> <u>deductible</u> doesn't apply	10% <u>coinsurance,</u> <u>deductible</u> doesn't apply	Non-emergency transport: not covered, except 30% <u>coinsurance</u> if pre-authorized.
	<u>Urgent care</u>	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	No coverage for non-urgent use.
lf you have a	Facility fee (e.g., hospital room)	No charge	30% <u>coinsurance</u>	Pre-authorization required for out-of-network care.
hospital stay	Physician/surgeon fees	No charge	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse	Outpatient services	Office: \$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply; other outpatient services: no charge	Office & other outpatient services: 30% <u>coinsurance</u>	None
services	Inpatient services	No charge	30% <u>coinsurance</u>	Pre-authorization required for out-of-network care.
	Office visits	No charge	30% coinsurance	Cost sharing does not apply for preventive
	Childbirth/delivery professional services	No charge	30% <u>coinsurance</u>	services. Maternity care may include tests &
lf you are pregnant	Childbirth/delivery facility services	No charge	30% <u>coinsurance</u>	services described elsewhere in the SBC (i.e. ultrasound.) <u>Pre-authorization</u> required for out-of-network care may apply.
If you need help	Home health care	No charge	30% <u>coinsurance</u>	Pre-authorization required for out-of-network care.
recovering or have other special health needs	Rehabilitation services	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>c</u> oinsurance	Out-of- <u>network</u> maximum: 75% of in- <u>network</u> cost up to \$52/visit for Physical Therapy.

		What Yo	u Will Pay	
Common Medical Event	Services You May Need	Aetna Whole Health In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Habilitation services	No charge	30% <u>coinsurance</u>	None
	Skilled nursing care	No charge	30% <u>coinsurance</u>	120 days/calendar year in- <u>network</u> & 60 days out-of-network/calendar year. <u>Pre-authorization</u> required for out-of-network care.
	Durable medical equipment	10% <u>coinsurance,</u> <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	No charge	30% <u>coinsurance</u>	Pre-authorization required for out-of-network care.
If your child needs	Children's eye exam	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not covered	1 routine eye exam/calendar year.
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
- Dental care (Adult & Child)
- Glasses (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> <u>services</u>.

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

- Private-duty nursing Acupuncture - Limited to disease, injury & Hearing aids - 1 hearing aid up to \$1,000 maximum per ear/24 months for children up chronic pain. Out-of-network maximum: 75% Routine eye care (Adult) - 1 routine eye exam/calendar of in-network cost up to \$60/visit. to age 16. year for in-network only. Bariatric surgery Infertility treatment - For more information & ٠ Chiropractic care - 30 visits/calendar year. exceptions, see policy document provided by your employer or call the number on your ID Out-of-network maximum: 75% of in-network
- Your Rights to Continue Coverage:

cost up to \$35/visit.

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

card.

- 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 <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>.
- 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 <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 <u>plan</u> 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:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number 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.
- 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? No.

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 hospital delivery)	anda	Managing Joe's Type 2 Diak (a year of routine in-network care of controlled condition)		Mia's Simple Fracture (in-network emergency room visit and care)	
 The <u>plan's</u> overall <u>deductible</u> <u>Specialist copayment</u> Hospital (facility) <u>copayment</u> Other <u>copayment</u> 	\$0 \$15 \$0 \$0	 The <u>plan's</u> overall <u>deductible</u> <u>Specialist copayment</u> Hospital (facility) <u>copayment</u> Other <u>copayment</u> 	\$C \$15 \$C \$C	 The <u>plan's</u> overall <u>deductible</u> <u>Specialist copayment</u> Hospital (facility) <u>copayment</u> Other <u>copayment</u> 	\$

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>		
<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	

= other <u>copayment</u>
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>		
Deductibles	\$0	
<u>Copayments</u>	\$100	
<u>Coinsurance</u>	\$0	
What isn't covered		
Limits or exclusions	\$4,300	
The total Joe would pay is	\$4,400	

This EXAMPLE event includes services like:

\$0 \$15 \$0 \$0

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	\$0
<u>Copayments</u>	\$200
Coinsurance	\$90
What isn't covered	
Limits or exclusions	\$10
The total Mia would pay is	\$300

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, or disability.

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.

TTY: 711

Language Assistance:

For language assistance in your language call 1-800-370-4526 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-800-370-4526.
Amharic -	ለቋንቋ እንዛ በ አማርኛ በ 1-800-370-4526 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 4526-370-450
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-800-370-4526 առանց գնով։
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-800-370-4526 ku busa
Bengali-Bangala -	ব াা ংলায় ভাষ া সহায়ত ার জন <i>ব</i> বন্াম ু ল ্ল্য 1-800-370-4526-তত কল কর ু ন ্।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-370-4526 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် ₁₋₈₀₀₋₃₇₀₋₄₅₂₆ ကို ခေါ် ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-800-370-4526.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-800-370-4526 sin gåstu.
Cherokee -	Ө֎ՋӨ Տ Օհ <i>Գ</i> ֎⅃ ⅃ℎ֎֍Ր֎Ջ ϴ Ե ͳ (CWУ) ᲢᲮWึ ^Ծ ℹ Տ 1-800-370-4526 ℺ϴፐ Ը АГ֎⅃ Ძℇ ႺՐ⅃ Ⴙ ℙℝϴ.
Chinese -	欲取得繁體中文語言協助,請撥打1-800-370-4526, 無需付費。
Choctaw -	(Chahta) anumpa y <u>a</u> apela a chi I p <u>a</u> ya hinla 1-800-370-4526.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-800-370-4526 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-370-4526.
French -	Pour une assistance linguistique en français appeler le 1-800-370-4526 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-370-4526 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-370-4526 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-370-4526 χωوἰς χϱἑωση.
Gujarati -	ગજરાતીમાાં ભાષામાાં સહાય માટે કોઈ પણ ખય વગર 1-800-370-4526 પર કૉલકરો.
Hawaiian -	No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-800-370-4526. Kāki 'ole 'ia kēia kōkua nei.

Hindi -	हनि्दी 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.
lbo -	Maka enyemaka asụsụ na Igbo kpọọ 1-800-370-4526 na akwụghị ụgwọ ọ bụla
llocano -	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 -	လ၊ တၢိမၢစၢၤတၢိကတိၤကိုုဉ်အင်္ဂါ ကိုုဉ် ကိုု800-370-4526 လ၊ တအိုဉ်ဒီးတၢိလ၊ ၁်ဘူဉ်လ၊ ၁်စူးဘဉ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-370-4526 번으로 전화해주십시오.
Kru-Bassa -	Ɓε´m`ké gbo-kpá-kpá dyé pidyi dé Ɓašɔɔ́-̀wùdุùùn wɛ̃ɛ, dá 1-800-370-4526
Kurdish -	بر اي ر اهنمايي به زبان فارسي با شمار ه 4526-370-800 به خور ايي يعيو مندي بكهن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ-800-370-4526 ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi -	কोण ाह ी शु लेळ् काश्रशवाय भाषा सेव ा ापळ्त कर ासाठी, 1-800-370-4526 वर फोन करा.
Marshallese - Micronesian-	Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-370-4526 ilo ejjelok wōnān.
Pohnpeyan -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-370-4526 ni sohte isais.
Mon-Khmer, Cambodian -	សម្ភាប់ជំនួយភាសាជា ភាសាខ្មមរៃ សូមទូរស័ព្ទទទៅកាន់លខេ 1-800-370-4526 ដហេយឥតគិតថ្លល់។
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) मवा न िः शु लः क भाषा सहायता पाउनकाो से ् ।
लाग ि 1-800	- 370-4526 म ा फ ोन ि ःनह्र Nilotic-Dinka- Tën kuɔɔny ë thok ë
Thuoŋjäŋ col 1-80	00-370- 4526 kecïn ayöc. Norwegian -For språkassistanse på norsk,
ring 1-800-370- 4	526 kostnadsfritt.
Panjabi - ਕਾਲ ਕਰ ੋ ।	ਪੰੰਜਾਬੀ ਵ ਿਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-370-4526 'ਤੇ ਮੁਫ਼ਤ
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-800-370-4526 aa. Es Aaruf koschtet nix.
Persian - Polish -	بر ای راهنمایی به زبان فارسی با شمار ه 1-800-370-4526 بدون هیچ هزینه ای تماس بگیرید. انگلیسی 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 heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 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 -	יאב שבה הי א הבאו מאה שלב ה ממואה הה לי ומהה אלא 1-800-370-4526 י
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-370-4526 nang walang bayad.
Telugu -	zyష�r0" యం s"రS0 ఎల ంe3 ఖరD.: "eS0ంG: 1-800-370-4526 S0 s>eS 0యంC. (�e.) ().)
Thai - ำหรับควำมชว	ส ยเหลอทำงดว⊳้นภำษำเป⊃็น ภำษำไทย โทร 1-800- คำใชจ้ำย 370- 4526 ฟรไมม
Tongan -	Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-800-370-4526 'o 'ikai hā ōtōngi.
Trukese -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-800-370-4526 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden1-800-370-4526.
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-370-4526.
Urdu -	بلاقیمت زیان سے متعلقہ خدمات حاصل کرتے کے لیے ، 4526-370-1.00 ۔ پر بات کریں۔
Vietnamese -	Đê được hố trợ ngôn ngự băng (ngôn ngự), hấy gọi miến phi đên số 1-800-370-4526.
Yiddish -	פאר שפראך הילף אין אידיש רופט 1-800-370-4526 פריי פון אפצאל.
Yoruba -	Fún ìrànlowo nípa èdè (Yorùbá) pe 1-800-370-4526 lái san owó kankan rárá.