Coverage for: Individual + Family | Plan Type: POS



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 1-888-982-3862. 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 1-888-982-3862 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	In- <u>Network</u> : Individual \$500 / Family \$1,000. 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 <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. Emergency care; plus in- <u>network</u> office visits & <u>preventive care</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <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> : Individual \$3,350 / Family \$6,700. Out-of-Network: Individual \$3,350 / Family \$6,700.	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> ?	<u>Premium</u> s, <u>balance-billing</u> 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 <u>www.aetna.com/docfind</u> or call 1-888- 982-3862 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
	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit, <u>deductible</u> doesn't apply	40% <u>coinsurance</u>	None
If you visit a health care <u>provider</u> 's office or clinic	<u>Specialist</u> visit	\$25 <u>copay</u> /visit, <u>deductible</u> doesn't apply	40% <u>coinsurance</u>	None
onice of clinic	Preventive care /screening /immunization	No charge	40% <u>coinsurance</u>	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)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition	Generic drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$10 (retail), \$20 (mail order)	40% <u>coinsurance</u> after \$10 <u>copay</u> /prescription, <u>deductible</u> doesn't apply (retail only)	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- approved women's contraceptives in- <u>network</u> . Review your <u>formulary</u> for prescriptions requiring step therapy for coverage. Maintenance drugs- no refill restrictions or penalties apply. Members
More information about <u>prescription</u> <u>drug coverage</u> is available at <u>www.aetna.com/pha</u>	Preferred brand drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$30 (retail), \$60 (mail order)	40% <u>coinsurance</u> after \$30 <u>copay</u> /prescription, <u>deductible</u> doesn't apply (retail only)	
rmacy- insurance/individual s-families	Non-preferred brand drugs	CODAV/DIESCODUOD		save with lower <u>copay</u> s at CVS Caremark® Mail Service Pharmacy or CVS Pharmacy.

Common Medical Event	eal Services You May Need In-Network Out-of-Network (You will pay the least) (You will pay the most) Limitations, Exceptions, & Othe		Limitations, Exceptions, & Other Important Information	
	<u>Specialty drugs</u>	Applicable cost as noted above for generic or brand drugs	Not covered	Emergency First prescription allowed at a retail pharmacy. Subsequent fills must be through CVS Specialty Pharmacy Only. Precertification required for coverage.
lf you have	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
outpatient surgery	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
lf you need	Emergency room care	20% <u>coinsurance</u> after \$100 <u>copay</u> /visit, <u>deductible</u> doesn't apply	20% <u>coinsurance</u> after \$100 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . No coverage for non-emergency use.
immediate medical attention	Emergency medical transportation	20% <u>coinsurance,</u> <u>deductible</u> doesn't apply	20% <u>coinsurance,</u> <u>deductible</u> doesn't apply	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>	\$25 <u>copay</u> /visit, <u>deductible</u> doesn't apply	40% <u>coinsurance</u>	No coverage for non-urgent use.
If you have a	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required for out-of-network care.
hospital stay	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse	Outpatient services	Office: \$25 <u>copay</u> /visit, <u>deductible</u> doesn't apply; other outpatient services: 20% <u>coinsurance</u>	Office & other outpatient services: 40% <u>coinsurance</u>	None
services	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required for out-of-network care.
If you are pregnant	Office visits Childbirth/delivery professional services	No charge 20% <u>coinsurance</u>	40% <u>coinsurance</u> 40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive</u> <u>services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e.,
n you are pregnant	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	ultrasound). <u>Pre-authorization</u> required for out-of- network care may apply.

	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
	Home health care	0% <u>coinsurance</u>	40% <u>coinsurance</u>	130 visits/calendar year. <u>Pre-authorization</u> required for out-of-network care.
If you need help recovering or have other special health needs	Rehabilitation services	\$25 <u>copay</u> /visit, <u>deductible</u> doesn't apply	40% coinsurance	60 visits/calendar year for Physical, Occupational & Speech Therapy combined.
	Habilitation services	20% <u>coinsurance</u> , except \$25 <u>copay</u> /visit, <u>deductible</u> doesn't apply for Neurodevelopmenta I Delay	40% <u>coinsurance</u>	None
	Skilled nursing care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	90 days/calendar year. <u>Pre-authorization</u> required 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.
	Hospice services	0% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required for out-of-network care.
l <b>f</b> your obild noods	Children's eye exam	Not covered	Not covered	Not covered.
If your child needs	Children's glasses	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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.) Routine eye care (Adult & Child) Cosmetic surgery Long-term care ٠ ٠ ٠ Dental care (Adult & Child) Non-emergency care when traveling outside Routine foot care ٠ ٠ . the U.S. Glasses (Child) Weight loss programs ٠ ٠ • Private-duty nursing

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

months.

- Acupuncture 12 visits/calendar year for disease, injury & chronic pain.
- Chiropractic care 10 visits/calendar year.
  Hearing aids \$3,000 maximum per ear/36
- Infertility treatment Limited to the diagnosis & treatment of underlying medical condition.

Bariatric surgery - \$10,000 maximum/lifetime.

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 1-888-982-3862.

- 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 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 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 1-888-982-3862. 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.
- 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? 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

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## 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)

\$500

\$25 20%

20%

The <u>plan's</u> overall <u>deductible</u>
Specialist copayment
Hospital (facility) <u>coinsurance</u>
Other <u>coinsurance</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>	\$500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,200
What isn't covered	
Limits or exclusions	\$70
The total Peg would pay is	\$2,770

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

The plan's overall deductible	\$500
Specialist copayment	\$25
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> Diabetic supplies (glucose meter)

Total Example Cost	\$5,600
In this example, Joe would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$300
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$4,300
The total Joe would pay is	\$4,700

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

The <u>plan's</u> overall <u>deductible</u>	\$500
Specialist copayment	\$25
Hospital (facility) <u>coinsurance</u>	20%
Other coinsurance	20%

#### This EXAMPLE event includes services like:

Emergency room care (including medical supplies) Diagnostic test (x-ray) Durable medical equipment (crutches) Rehabilitation services (physical therapy)

Total Example Cost	\$2,800
In this example, Mia would pay:	
Cost Sharing	
Deductibles	\$0
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$400
What isn't covered	
Limits or exclusions	\$10
The total Mia would pay is	\$510

#### **Assistive Technology**

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-982-3862.

#### **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 1-888-982-3862.

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Armenian -Utių duup įtequlujuub dumujunįpijni tilutipijo quruj tijni huutuup quiliquuhupitip 1-888-982-3862 himuljunuuhuutuupinųi:Bahasa Indonesia -Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya.Bantu-Kirundi -Kugira uronke serivisi zindimi atakiguzi, hamagara 1-888-982-3862.Bengali-Bangala -আপনাকে বিনাহুকথে ভাষা পৰিকাষ্ পশকে হকৰ এই নগকি পেৰমক ান come: 1-888-982-3861Bisayan-Visayan -Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-888-982-3862.Burmese -మర్గంపాలు (G అలుగుథ) రామాంగాగుంథం: యార్లు గుళ్ళిల్ల క్షి 1-888-982-3862.Chamorro -Para un hago'i setbision lengguåhi ni dibåtde para hågu, ågang 1-888-982-3862.Chamorro -Para un hago'i setbision lengguåhi ni dibåtde para hågu, ågang 1-888-982-3862.Cherokee -Gyrðu SOShaðoù O'G'O do' AL f a faðu T dEGGW ALT 5AV, Øh-AbWorb 1-888-982-3862.Chinese -ytirtik tagta falla Battik anga ta raga chuuf, bilbili 1-888-982-3862.Cushite -Tajaajilloota afaanii garuu bilisaa ati argaachuuf, bilbili 1-888-982-3862.Dutch -Voor gratis toegang tot taaldiensten, bell 1-888-982-3862.French -Afin d'accéder aux services langagiers sans frais, composez le 1-888-982-3862.French -Pou jwenn sèvis lang gratis, rele 1-888-982-3862.German -Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-888-982-3862 an.Greek -Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσοα σας, τηλεφωνήστε στον αριθμό 1-888-982-3862.	Amharic -	የቋንቋ አንልግሎቶችን ያለክፍያ ለማግኘት፣ በ ነ-888-982-3862 ይደውሉ።
Bahasa Indonesia -Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya.Bahasa Indonesia -Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-888-982-3862.Bengal-Bangala -यात्रतारक कितापृल्पा छात्रा शर्विश्वी १९९८ कृत्वर वरे तत्रवि ८९वगर ठात ८०वनर 1-888-982-3861Bisayan-Visayan -Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-888-982-3862.Burmese -သင့္ဆေရျဖင့္ အခေၾကးေငြ မေပးရပဲ ဘာသာemmeape ဆာင္အျမိဳး ရရွိႏုိင္ရန္ 1-888-982-3862 သို႕ ဖုန္းေခၚဆုိပါ။Catalan -Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-888-982-3862.Chamoro -Para un hago' i setbision lengguàhi ni dibâtde para hâgu, âgang 1-888-982-3862.Cherokee -Gyöð J SQDh.Øðð J OGØ66°/J J C AFðð J JGEGW.J J & SV, ØÞ.ØbWo°b 1-888-982-3862.Chinese -ythty ph pilla ho ish I paya hinla, I paya 1-888-982-3862.Chotaw -Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-888-982-3862.Dutch -Voor gratis toegang tot taaldiensten, bell 1-888-982-3862.Dutch -Voor gratis toegang tot taaldiensten, bell 1-888-982-3862.French Creole -Pou jwenn sèvis lang gratis, rele 1-888-982-3862.French Creole -Pou jwenn sèvis lang gratis, rele 1-888-982-3862.German -Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-888-982-3862 an.Greek -Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-888-982-3862.	Arabic -	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء االتصال على الرقم 3862-982-1888-1
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Indonesian -	Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-888-982-3862.
Italian -	Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-888-982-3862.
Japanese -	言語サービスを無料でご利用いただくには、1-888-982-3862 までお電話ください。
Karen -	လ၊တါကမၤန္နါကိုဉ်အတါမၤစၢၤအတၢဖ်ဴးတါမၤတဖဉ်လ၊တအိဉ်ဒီးအၦ္ဒၤလ၊ကဘဉ်ဟ့ဉ်အီၤအဂ်ီ၊်ဘဉ်နှဉ် ကိး 1-888-982-3862 တက္၊်
Korean -	무료 언어 서비스를 이용하려면 1-888-982-3862 번으로 전화해 주십시오.
Kru-Bassa -	Μ dyi wuqu-dù kà kò qò ɓĕ dyi mɔú ń nì Pídyi ní, nìí, qá nɔ̀ɓà nìà kɛ: 1-888-982-3862
Kurdish -	بۆ دەسپێراگەيشتن بە خزمەتگوزارى زمان بەبى نێچوون بۆ نۆ، پەيوەندى بكە بە ژمارەي 3862-982-1888-1
Laotian -	ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ1-888-982-3862
Marathi -	कोणत्याही शल्ुकालशवाय भाषा सेवा प्राप्त करण्यासाठी,, 1-888-982-3862 वर फोन करा.
Marshallese - Micronesian-	Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-888-982-3862.
Pohnpeyan -	Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-888-982-3862.
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' 1-888-982-3862.
Nepali -	निःशुल्क भाषा सेवा प्राप्त गर्न 1-888-982-3862 मा टेलिफोन गर्नुहोस् ।
Nilotic-Dinka -	Të koor yïn weër de thokic ke cin wëu kor keek tënon yïn. Ke col koc ye koc kuony ne nomba 1-888-982-3862.
Norwegian -	For tilgang til kostnadsfri språktjenester, ring 1-888-982-3862.
Pennsylvania Dutch -	Um Schprooch Services zu griege mitaus Koscht, ruff 1-888-982-3862.
Persian -	بر ای دسترسی به خدمات زبان به طور رایگان، با شماره 3862-982-1888 تماس بگیرید .
Polish -	Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-888-982-3862.
Portuguese -	Para acessar os serviços de idiomas sem custo para você, ligue para 1-888-982-3862.

Punjabi -	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-888-982-3862 'ਤੇ ਫ਼ੋਨ ਕਰੋ।
Romanian -	Pentru a accesa gratuit serviciile de limbă, apelați 1-888-982-3862.
Russian -	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-888-982-3862.
Samoan -	Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-888-982-3862.
Serbo-Croatian -	Za besplatne prevodilačke usluge pozovite 1-888-982-3862.
Spanish -	Para acceder a los servicios de idiomas sin costo, llame al 1-888-982-3862.
Sudanic-Fulfude -	Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-888-982-3862.
Swahili -	Kupata huduma za lugha bila malipo kwako, piga 1-888-982-3862.
Syriac -	:مهبقه، مدبقه، جل سلخط، الله، الله، المانية، المانية، منه، منه، منه، منه، منه، منه، منه، منه
Tagalog -	Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-888-982-3862.
Telugu -	మీరు భాష సేవలను ఉచితంగా అందుకునందుకు, 1-888-982-3862 కు కాల్ చేయండి.
Thai -	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-888-982-3862.
Tongan -	Kapau 'oku ke fiema'u ta'etōtōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-888-982-3862.
Trukese -	Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-888-982-3862.
Turkish -	Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-888-982-3862 numarayı arayın.
Ukrainian -	Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-888-982-3862.
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 1-888-982-3862
Yiddish -	צו צוטריט שפרַאך בַאדינונגען אין קיין פרייַז צו איר, רופן 1-888-982-3862
Yoruba -	Lati wọnú awọn ise èdè l'ofe fun o, pe 1-888-982-3862.