



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](http://www.HealthReformPlanSBC.com) or by calling 1-800-370-4526. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-800-370-4526 to request a copy.

| Important Questions                                                | Answers                                                                                                                                                    | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|--------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall deductible?</b>                             | \$0. Out-of-Network: Individual \$100 / Family \$250.                                                                                                      | 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> .                                                                                                                                                               |
| <b>Are there services covered before you meet your deductible?</b> | Yes. Emergency care 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>                                              |
| <b>Are there other deductibles for specific services?</b>          | No.                                                                                                                                                        | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>What is the out-of-pocket limit for this plan?</b>              | In-Network: Individual \$400 / Family \$1,000.<br>Rx Maximums: Individual \$1,890 / Family \$3,780<br>Out-of-Network: Individual \$2,000 / Family \$5,000. | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.                                                                                                                                                                                                                                                                                     |
| <b>What is not included in the out-of-pocket limit?</b>            | <u>Premiums</u> , <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> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Will you pay less if you use a network provider?</b>            | Yes. See <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-800-370-4526 for a list of in-network providers.                       | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| <b>Do you need a referral to see a specialist?</b>                 | No.                                                                                                                                                        | You can see the <u>specialist</u> you choose without a <u>referral</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |



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

| Common Medical Event                                                                                                                                                                                                                                                                | Services You May Need                                   | What You Will Pay                                         |                                                                                                                | Limitations, Exceptions, & Other Important Information                                                                                                                  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|-----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                     |                                                         | In-Network Provider<br>(You will pay the least)           | Out-of-Network Provider<br>(You will pay the most)                                                             |                                                                                                                                                                         |
| <b>If you visit a health care <u>provider's</u> office or clinic</b>                                                                                                                                                                                                                | Primary care visit to treat an injury or illness        | \$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply | 20% <u>coinsurance</u>                                                                                         | None                                                                                                                                                                    |
|                                                                                                                                                                                                                                                                                     | <u>Specialist</u> visit                                 | \$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply | 20% <u>coinsurance</u>                                                                                         | None                                                                                                                                                                    |
|                                                                                                                                                                                                                                                                                     | <u>Preventive care</u> / <u>screening</u> /immunization | No charge                                                 | 20% <u>coinsurance</u> , <u>deductible</u> doesn't apply; except routine physicals & immunizations not covered | 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. |
| <b>If you have a test</b>                                                                                                                                                                                                                                                           | <u>Diagnostic test</u> (x-ray, blood work)              | No charge                                                 | 20% <u>coinsurance</u>                                                                                         | None                                                                                                                                                                    |
|                                                                                                                                                                                                                                                                                     | Imaging (CT/PET scans, MRIs)                            | No charge                                                 | 20% <u>coinsurance</u>                                                                                         | None                                                                                                                                                                    |
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.aetna.com/pharmacy-insurance/individuals-families">www.aetna.com/pharmacy-insurance/individuals-families</a> | Generic drugs                                           | \$3 copay retail<br>\$0 copay mail order                  | Not covered                                                                                                    | 30 day supply at retail. Up to 90 day supply through mail order                                                                                                         |
|                                                                                                                                                                                                                                                                                     | Preferred brand drugs                                   | \$10 copay retail<br>\$15 copay retail                    | Not covered                                                                                                    |                                                                                                                                                                         |
|                                                                                                                                                                                                                                                                                     | Non-preferred brand drugs                               | \$10 copay retail<br>\$15 copay retail                    | Not covered                                                                                                    |                                                                                                                                                                         |
|                                                                                                                                                                                                                                                                                     | <u>Specialty drugs</u>                                  | Same as retail                                            | Not covered                                                                                                    | Specialty medications must be filled through Accredo Specialty Pharmacy                                                                                                 |

| Common Medical Event                                                             | Services You May Need                                                    | What You Will Pay                                                                                       |                                                            | Limitations, Exceptions, & Other Important Information                                                                                                                                                                           |
|----------------------------------------------------------------------------------|--------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                  |                                                                          | In-Network Provider<br>(You will pay the least)                                                         | Out-of-Network Provider<br>(You will pay the most)         |                                                                                                                                                                                                                                  |
| <b>If you have outpatient surgery</b>                                            | Facility fee (e.g., ambulatory surgery center)<br>Physician/surgeon fees | No charge<br>No charge                                                                                  | 20% <u>coinsurance</u><br>20% <u>coinsurance</u>           | None<br>None                                                                                                                                                                                                                     |
| <b>If you need immediate medical attention</b>                                   | <u>Emergency room care</u>                                               | \$25 <u>copay</u> /visit, <u>deductible</u> doesn't apply                                               | \$25 <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.                                                                                                                    |
|                                                                                  | <u>Emergency medical transportation</u>                                  | 10% <u>coinsurance</u> , <u>deductible</u> doesn't apply                                                | 10% <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>                                                       | \$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply                                               | 20% <u>coinsurance</u>                                     | None                                                                                                                                                                                                                             |
| <b>If you have a hospital stay</b>                                               | Facility fee (e.g., hospital room)                                       | No charge                                                                                               | 20% <u>coinsurance</u> after \$200 <u>copay</u> /stay      | <u>Pre-authorization</u> required for out-of-network care.                                                                                                                                                                       |
|                                                                                  | Physician/surgeon fees                                                   | No charge                                                                                               | 20% <u>coinsurance</u>                                     | None                                                                                                                                                                                                                             |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                                                      | Office: \$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply; other outpatient services: no charge | Office & other outpatient services: 20% <u>coinsurance</u> | None                                                                                                                                                                                                                             |
|                                                                                  | Inpatient services                                                       | No charge                                                                                               | 20% <u>coinsurance</u> after \$200 <u>copay</u> /stay      | <u>Pre-authorization</u> required for out-of-network care.                                                                                                                                                                       |
| <b>If you are pregnant</b>                                                       | Office visits                                                            | No charge                                                                                               | 20% <u>coinsurance</u>                                     | <u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). <u>Pre-authorization</u> for out-of-network care may apply. |
|                                                                                  | Childbirth/delivery professional services                                | No charge                                                                                               | 20% <u>coinsurance</u>                                     |                                                                                                                                                                                                                                  |
|                                                                                  | Childbirth/delivery facility services                                    | No charge                                                                                               | 20% <u>coinsurance</u> after \$200 <u>copay</u> /stay      |                                                                                                                                                                                                                                  |
| <b>If you need help recovering or have</b>                                       | <u>Home health care</u>                                                  | No charge                                                                                               | 20% <u>coinsurance</u>                                     | <u>Pre-authorization</u> required for out-of-network care.                                                                                                                                                                       |

| Common Medical Event                   | Services You May Need            | What You Will Pay                                         |                                                                                                            | Limitations, Exceptions, & Other Important Information                                                                               |
|----------------------------------------|----------------------------------|-----------------------------------------------------------|------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|
|                                        |                                  | In-Network Provider<br>(You will pay the least)           | Out-of-Network Provider<br>(You will pay the most)                                                         |                                                                                                                                      |
| other special health needs             | <u>Rehabilitation services</u>   | \$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply | 20% <u>coinsurance</u>                                                                                     | Out-of-network maximum: 75% of in-network cost up to \$52/visit for Physical Therapy.                                                |
|                                        | <u>Habilitation services</u>     | No charge                                                 | 20% <u>coinsurance</u>                                                                                     | None                                                                                                                                 |
|                                        | <u>Skilled nursing care</u>      | No charge                                                 | 20% <u>coinsurance</u> after \$200 <u>copay</u> /stay                                                      | 120 days/calendar year in-network & 60 days out-of-network/calendar year. <u>Pre-authorization</u> required for out-of-network care. |
|                                        | <u>Durable medical equipment</u> | 10% <u>coinsurance</u> , <u>deductible</u> doesn't apply  | 20% <u>coinsurance</u>                                                                                     | Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.                           |
|                                        | <u>Hospice services</u>          | No charge                                                 | 20% <u>coinsurance</u> after \$200 <u>copay</u> /stay for inpatient; 20% <u>coinsurance</u> for outpatient | <u>Pre-authorization</u> required for out-of-network care.                                                                           |
| If your child needs dental or eye care | Children's eye exam              | \$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply | Not covered                                                                                                | 1 routine eye exam/calendar year.                                                                                                    |
|                                        | 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.
- Prescription drugs
- Routine foot care
- Weight loss programs

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

- Acupuncture - Limited to disease, injury & chronic pain. Out-of-network: 75% of in-network cost up to \$60/visit.
- Bariatric surgery
- Chiropractic care - 30 visits/calendar year. Out-of-network: 75% of in-network cost up to \$35/visit.
- Hearing aids - 1 hearing aid to \$2,500 maximum per ear/60 months.
- Infertility treatment - For more information & exceptions, see policy document provided by your employer or call the number on your ID card.
- Private-duty nursing
- Routine eye care (Adult) - 1 routine eye exam/calendar year for in-network only.

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

- For more information on your rights to continue coverage, contact the plan at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/ebsa/healthreform>
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-800-370-4526. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/ebsa/healthreform>
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: <http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html>.

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

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

**Does this plan meet Minimum Value Standards? 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 plan might cover costs for a sample medical situation, see the next section*

## About these Coverage Examples:



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

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

|                                               |      |
|-----------------------------------------------|------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$0  |
| ■ <u>Specialist copayment</u>                 | \$10 |
| ■ Hospital (facility) <u>copayment</u>        | \$0  |
| ■ Other <u>copayment</u>                      | \$0  |

#### This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
Diagnostic tests (*ultrasounds and blood work*)  
Specialist visit (*anesthesia*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

#### In this example, Peg would pay:

| <u>Cost Sharing</u>               |             |
|-----------------------------------|-------------|
| <u>Deductibles</u>                | \$0         |
| <u>Copayments</u>                 | \$0         |
| <u>Coinsurance</u>                | \$0         |
| <u>What isn't covered</u>         |             |
| Limits or exclusions              | \$70        |
| <b>The total Peg would pay is</b> | <b>\$70</b> |

### Managing Joe's Type 2 Diabetes

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

|                                               |      |
|-----------------------------------------------|------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$0  |
| ■ <u>Specialist copayment</u>                 | \$10 |
| ■ Hospital (facility) <u>copayment</u>        | \$0  |
| ■ Other <u>copayment</u>                      | \$0  |

#### This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
Diagnostic tests (*blood work*)  
Prescription drugs  
Diabetic supplies (*glucose meter*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

#### In this example, Joe would pay:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$0            |
| <u>Copayments</u>                 | \$100          |
| <u>Coinsurance</u>                | \$0            |
| <u>What isn't covered</u>         |                |
| Limits or exclusions              | \$4,300        |
| <b>The total Joe would pay is</b> | <b>\$4,400</b> |

### Mia's Simple Fracture

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

|                                               |      |
|-----------------------------------------------|------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$0  |
| ■ <u>Specialist copayment</u>                 | \$10 |
| ■ 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

#### In this example, Mia would pay:

| <u>Cost Sharing</u>               |              |
|-----------------------------------|--------------|
| <u>Deductibles</u>                | \$0          |
| <u>Copayments</u>                 | \$80         |
| <u>Coinsurance</u>                | \$90         |
| <u>What isn't covered</u>         |              |
| Limits or exclusions              | \$10         |
| <b>The total Mia would pay is</b> | <b>\$180</b> |

### **Assistive Technology**

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-370-4526.

### **Smartphone or Tablet**

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

### **Non-Discrimination**

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, disability, gender identity or sexual orientation.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,  
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),  
1-800-648-7817, TTY: 711,  
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), [CRCoordinator@aetna.com](mailto: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).

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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 አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-800-370-4526 ይደውሉ።                                                                           |
| Arabic -           | للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-800-370-4526                                            |
| Armenian -         | Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-800-370-4526 հեռախոսահամարով:                                 |
| Bahasa Indonesia - | Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.                                 |
| Bantu-Kirundi -    | Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-800-370-4526.                                                         |
| Bengali-Bangala -  | আপনাকে বিনামূল্যে ভাষা পবিকষিা পপকে হকয এই নম্বকি পেবযক ান েরন: 1-800-370-4526।                                             |
| Bisayan-Visayan -  | Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-800-370-4526.                                       |
| Burmese -          | သင့်အတွက် အခမဲ့ဘာသာစကားဝန်ဆောင်မှုရရှိလိုသည့် 1-800-370-4526 သို့ ဖုန်းခံခံသင့်ပါ။                                          |
| 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 -         | Ⴀႃ႗ႃႉ Ⴑ႗႗႗႗႗ Ⴑ႗႗႗႗႗ Ⴑ႗႗႗႗႗ Ⴑ႗႗႗႗႗ Ⴑ႗႗႗႗႗ Ⴑ႗႗႗႗႗ 1-800-370-4526.                                                             |
| Chinese -          | 如欲使用免費語言服務，請致電 1-800-370-4526.                                                                                              |
| Choctaw -          | Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-800-370-4526.                                          |
| Cushite -          | Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-800-370-4526.                                                  |
| Dutch -            | Voor gratis toegang tot taaldiensten, bell 1-800-370-4526.                                                                  |
| French -           | Afin d'accéder aux services langagiers sans frais, composez le 1-800-370-4526.                                              |
| French Creole -    | Pou jwenn sèvis lang gratis, rele 1-800-370-4526.                                                                           |
| German -           | Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-800-370-4526 an.                                  |
| Greek -            | Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-800-370-4526. |
| Gujarati -         | તમારેકોઇ જાતના ખર્ચવિના ભાષાની સેવાઓની પહોંર 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.                                               |
| Igbo -                 | Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ 1-800-370-4526                                                             |
| Ilocano -              | Tapno maaksesyô 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 -                | လၢတၢ်ကမၤန့ၢ်ကျိၣ်အတၢ်မၤစၢၤအတၢ်ဖဲတၢ်မၤတဖၣ်လၢတအိၣ်ဒီးအပူၤလၢကဘၣ်ဟ့ၣ်အိၣ်အဂီၢ်ဘၣ်န့ၣ် ကိး 1-800-370-4526 တက့ၢ်.             |
| Korean -               | 무료 언어 서비스를 이용하려면 1-800-370-4526 번으로 전화해 주십시오.                                                                           |
| Kru-Bassa -            | M̐ dyi wuḍu-dù kà kò ḍò bě dyi m̐ú n̐ nì Pídyi ní, níí, ḍá nòbà nà kɛ: 1-800-370-4526                                   |
| Kurdish -              | بۆ دەسپێرانیشتن بە خزمەتگوزاری زمان بەی تێچوون بۆ تۆ، پەیوەندی بکە بە ژمارەی 1-800-370-4526                             |
| Laotian -              | ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-800-370-4526                                            |
| Marathi -              | कोणत्याही शल्ुकालशवाय भाषा सेवा प्राप्त करण्यासाठी,, 1-800-370-4526 वर फोन करा.                                         |
| Marshallese -          | Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-800-370-4526.                                |
| Micronesian-           |                                                                                                                         |
| Pohnpeyan -            | Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-800-370-4526.                                             |
| Mon-Khmer, Cambodian - | ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-800-370-4526 ។                             |
| Navajo -               | T'áá ni nizaad k'ehjí bee níká a'doowoł doo báąh ílínígóó koji' hólne' 1-800-370-4526.                                  |
| Nepali -               | निःशुल्क भाषा सेवा प्राप्त गर्न 1-800-370-4526 मा टेलिफोन गर्नुहोस् ।                                                   |
| Nilotic-Dinka -        | Të koor yin wɛɛr de thokic ke cīn wëu kɔr keek tənɔŋ yīn. Ke cɔl kɔc ye kɔc kuɔny ne nɔmba 1-800-370-4526.              |
| Norwegian -            | For tilgang til kostnadsfri språktjenester, ring 1-800-370-4526.                                                        |
| Pennsylvania Dutch -   | Um Schprooch Services zu griege mitaus Koscht, ruff 1-800-370-4526.                                                     |
| Persian -              | برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-800-370-4526 تماس بگیرید .                                          |
| Polish -               | Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-800-370-4526.                                     |
| Portuguese -           | Para acessar os serviços de idiomas sem custo para você, ligue para 1-800-370-4526.                                     |

