



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:
<u>What is the overall deductible?</u>	In- <u>Network</u> : Individual \$100 / Family \$0. Out-of- <u>Network</u> : Individual \$400 / 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> .
<u>Are there services covered before you meet your deductible?</u>	Yes. Emergency care & <u>preventive care</u> ; plus in- <u>network</u> office visits & inpatient hospital services 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
<u>Are there other deductibles for specific services?</u>	No.	You don't have to meet <u>deductibles</u> for specific services.
<u>What is the out-of-pocket limit for this plan?</u>	In- <u>Network</u> : Individual \$800 / Family \$2,000. Rx Maximum: Individual \$1,890 / Family \$3,780 Out-of- <u>Network</u> : 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.
<u>What is not included in the out-of-pocket limit?</u>	<u>Premiums</u> , 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> .
<u>Will you pay less if you use a network provider?</u>	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- <u>network</u> 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 charge</u> 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.
<u>Do you need a referral to see a specialist?</u>	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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$15 <u>copay</u> /visit <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$15 <u>copay</u> /visit <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	None
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge. <u>Deductible</u> does not apply.	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.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	30% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	No charge	30% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition  More information about <u>prescription drug coverage</u> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a>	Generic drugs	\$7 <u>copay</u> retail; \$0 <u>copay</u> mail order	Not covered	Up to 30-day supply retail Up to 90-day supply mail order
	Preferred brand drugs	\$16 <u>copay</u> retail; \$40 <u>copay</u> mail order	Not covered	
	Non-preferred brand drugs	Member pays difference between preferred <u>copay</u> and cost of medication for retail and mail order	Not covered	
	<u>Specialty</u> drugs	Same as retail	Not covered	Specialty medication must be filled through Accredo Specialty Pharmacy
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge. <u>Deductible</u> does not apply.	30% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	No charge. <u>Deductible</u> does not apply.	30% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$50 <u>copay/visit</u> <u>deductible</u> doesn't apply	\$50 <u>copay/visit</u> <u>deductible</u> doesn't apply	Out-of-network emergency use paid the same as in-network. No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to local emergency transport to the nearest facility equipped to treat the emergency condition
	<u>Urgent care</u>	\$15 <u>copay/visit</u> <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge. <u>Deductible</u> does not apply.	30% <u>coinsurance</u>	Pre-authorization required for out-of-network care. There is a separate \$500 <u>deductible</u> per inpatient stay for out-of-network facilities.
	Physician/surgeon fees	No charge. <u>Deductible</u> does not apply.	30% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 <u>copay</u> per Office visit for Mental and Behavioral Health.	30% <u>coinsurance</u>	None
	Inpatient services	No charge	30% <u>coinsurance</u>	Pre-authorization required for out-of-network care. There is a separate \$500 <u>deductible</u> per inpatient stay for out-of-network facilities.
If you are pregnant	Office visits	\$15 <u>copay</u> per Office visit. <u>Deductible</u> does not apply.	30% <u>coinsurance</u>	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Pre-authorization required for out-of-network care may apply. There is a separate \$500 <u>deductible</u> per inpatient stay for out-of-network facilities.
	Childbirth/delivery professional services	No charge. <u>Deductible</u> does not apply.	30% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Childbirth/delivery facility services	No charge. <u>Deductible</u> does not apply.	30% <u>coinsurance</u>	
	<u>Home health care</u>	No charge. <u>Deductible</u> does not apply.	30% <u>coinsurance</u>	Pre-authorization required for out-of-network care.
	<u>Rehabilitation services</u>	\$15 <u>copay</u> per Office visit. No charge for Inpatient and Outpatient Facility. <u>Deductible</u> does not apply.	30% <u>coinsurance</u>	Out-of-network maximum: 75% of in-network cost up to \$52/visit for Physical Therapy. There is a separate \$500 <u>deductible</u> per inpatient stay for out-of-network facilities.
	<u>Habilitation services</u>	\$15 <u>copay</u> per Office visit. No charge for Inpatient and Outpatient Facility. <u>Deductible</u> does not apply.	30% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	No charge. <u>Deductible</u> does not apply.	30% <u>coinsurance</u>	120 days/calender year INN. 60 days/calender year OON. For a combined total of 120 days/calender year. Pre-authorization required for out-of-network care. There is a separate \$500 <u>deductible</u> per inpatient stay for out-of-network facilities.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
If your child needs dental or eye care	<u>Hospice services</u>	No charge. <u>Deductible</u> does not apply.	30% <u>coinsurance</u>	Pre-authorization required for out-of-network care. There is a separate \$500 <u>deductible</u> per inpatient stay for out-of-network facilities.
If your child needs dental or eye care	Children's eye exam	\$15 <u>copay/visit</u> <u>deductible</u> doesn't apply	Not covered	1 routine eye exam/calender year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	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 preventive services.

#### 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 coverage limited to \$60 a visit for acupuncture or 75% of the in network cost per visit, whichever is less.
- Bariatric surgery
- Chiropractic care - 30 visits/calendar year. Limited to \$35/visit Out-of-Network.
- Hearing aids - 1 hearing aid to \$1,000 maximum per ear/24 months for children up to age 16.
- 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 overall deductible</u>	\$100
■ <u>Specialist copayment</u>	\$15
■ <u>Hospital (facility) copayment</u>	\$0
■ <u>Other 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>
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**In this example, Peg would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
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 overall deductible</u>	\$100
■ <u>Specialist copayment</u>	\$15
■ <u>Hospital (facility) copayment</u>	\$0
■ <u>Other copayment</u>	\$0

**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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$4,300
<b>The total Joe would pay is</b>	<b>\$4,500</b>

### Mia's Simple Fracture

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

■ The <u>plan's overall deductible</u>	\$100
■ <u>Specialist copayment</u>	\$15
■ <u>Hospital (facility) copayment</u>	\$0
■ <u>Other 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>
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**In this example, Mia would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$80
<u>Coinsurance</u>	\$80
<i>What isn't covered</i>	
Limits or exclusions	\$10
<b>The total Mia would pay is</b>	<b>\$270</b>

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-370-4526.

## Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 866-393-0002.

## Smartphone or Tablet

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

## Non-Discrimination

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

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

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

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

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

**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 -	ለቻቸ አገል በ አማርኛ በ 1-800-370-4526 በነፃ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-370-4526
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-800-370-4526 առանց զնով:
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 -	বাংলায় ভাষা সহায়তার জন্য বিনামূলে 1-800-370-4526-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-370-4526 nga walay bayad.
Burmese -	မြန်မာ့ဘာသာစကား ဖြင့် ဘာသာစကားအကျိုအညီရပါန် 1-800-370-4526 တို့ ခေါ်ဆိုပါ။
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 gästu.
Cherokee -	Thetau Selihaonla JihonDRooy UtT (GWY) ObW6'iS 1-800-370-4526 OTHT L AGoDLa JEGPL hFRTheta.
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 ya_apela a chi I paya 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 γλωσσιακή βοήθεια στα Ελληνικά καλέστε το 1-800-370-4526 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-800-370-4526 પર કોલ કરો.
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 -	हिन्दी में भाषा सहायता के लिए, 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.
Ibo -	Maka enyemaka asusu na Igbo kpoo 1-800-370-4526 na akwughị ụgwọ ọ bụla
Ilocano -	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 -	လာဝါမာစာတိကတိုင်အော် ကျိုး 1-800-370-4526 လာဝါအိုင်ဒီးတို့လာ်ဘုံးလာ်စွာဘာ့
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-370-4526 번으로 전화해 주십시오.
Kru-Bassa -	Be'm'ke gbo-kpá-kpá dyé piidyi qé Bašoo-wuquun wéé, qá 1-800-370-4526
Kurdish -	برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 به خور ای پیموندی بگهن.
Laotian -	ທ້າທ່ານຕົ້ນງານຄວາມຊັບຍໍ້ໃນການແປພາສາລາວ, ກະລຸນາໄທທາ 1-800-370-4526 ໄດ້ຍິ່ນເສຍຄ່າໄທ.
Marathi -	कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-800-370-4526 वर फोन करा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-370-4526 ilo ejjelok wōnān.
Micronesian- Pohnpeyan -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-370-4526 ni sohte isais.
Mon-Khmer, Cambodian -	សមුෂ්‍රප්‍රදී ຢාකාසාධී ກාසාදුම් ສුජ්‍යුස් ຖ්‍රුණෑං ກාක්ක්ලාං 1-800-370-4526 ຜ්‍රායක්ක්ක්ෂ්ං ໄ
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) मा निःशुल्क भाषा सहायता पाउनका लागि 1-800-370-4526 मा फोन गर्नुहोस्।
Nilotic-Dinka -	Tén kuɔny ë thok ë Thuɔnjän̄ cɔl 1-800-370-4526 kecín aycöc.
Norwegian -	For språkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt.
Punjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਰਾਇਤਾ ਲਈ, 1-800-370-4526 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-800-370-4526 aa. Es Aaruf koschtet nix.
Persian -	برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	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 română 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 hebu balal e ko yowitii e haala Pular noddee e oo numero doo 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 -	ܩ ໂ 800 370 4526 1-800-370-4526 .
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-370-4526 nang walang bayad.
Telugu -	భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-800-370-4526 కు కాల్ చేయండి. (తెలుగు)
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-800-370-4526 ฟรีไม่มีค่าใช้จ่าย
Tongan -	Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-800-370-4526 'o 'ikai hā ōtōngi.
Trukese -	Ren ánninsin chiakú ren (Kapasen Chuuk) kopwe kékkeéri 1-800-370-4526 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-800-370-4526.
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-370-4526.
Urdu -	بلاقیمک زیان سے متعلق خدمات حاصل کرنے کے لئے 1-800-370-4526۔ یہ بات کریں۔
Vietnamese -	Để được hỗ trợ ngôn ngữ <b>bảng</b> (ngôn ngữ), hãy gọi miễn phí <b>đến</b> 1-800-370-4526.
Yiddish -	פֿאָר שְׁפָרָאָר הַילַּךְ אַיְדִּישׁ רַופָּאַל 1-800-370-4526
Yoruba -	Fún ìrànlòwò nípa èdè (Yorùbá) pe 1-800-370-4526 lái san owó kankan rará.