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 1-877-292-2480. 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/](https://www.healthcare.gov/sbc-glossary/) or call 1-877-292-2480 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>Network: Individual $100 / Family $300. Out-of-Network: Individual $450 / Family $1,350.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. Emergency care &amp; inpatient hospital services; plus in-network office visits &amp; preventive care are covered before you meet your deductible.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>Network: Individual $2,000 / Family $4,000. Out-of-Network: Individual $3,000 / Family $6,000. Prescription drugs: Individual $1,200 / Family $3,600.</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums, balance-billing charges &amp; health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td><strong>Will you pay less if you use a network provider?</strong></td>
<td>Yes. See <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-877-292-2480 for a list of Aexcel designated providers.</td>
<td>You pay the least if you use a provider in Aexcel Designated. You pay more if you use a provider in Network or Aexcel Non-Designated. You will pay the most if you use an out-of-network provider and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td><strong>Do you need a referral to see a specialist?</strong></td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Aexcel Designated Provider (You will pay the least)</th>
<th>Network Provider (You will pay more)</th>
<th>Aexcel Non-Designated Provider (You will pay more)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>Not applicable</td>
<td>$15 copay/visit, deductible doesn't apply</td>
<td>$15 copay/visit, deductible doesn't apply</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>No charge</td>
<td>Not applicable</td>
<td>Not covered, except 40% coinsurance for mammograms &amp; gynecological exams</td>
<td></td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>Not applicable</td>
<td>10% coinsurance</td>
<td>Not applicable</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>Not applicable</td>
<td>10% coinsurance</td>
<td>Not applicable</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>Not applicable</td>
<td>30% coinsurance with minimum &amp; maximum/prescription: $10 minimum &amp; $100 maximum (retail), $20 minimum &amp; $200 maximum (mail order)</td>
<td>Not applicable</td>
<td>Not covered</td>
<td>Covers 31 day supply (retail), 32-90 day supply (mail order). Includes contraceptive drugs &amp; devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women’s contraceptives in-network.</td>
</tr>
</tbody>
</table>

**More information about prescription drug coverage** is available at...
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Aexcel Designated Provider (You will pay the least)</th>
<th>Network Provider (You will pay more)</th>
<th>Aexcel Non-Designated Provider (You will pay more)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="http://www.aetnapharmacy.com/premierplus">www.aetnapharmacy.com/premierplus</a></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premier Plus Formulary</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preferred brand drugs</td>
<td>Not applicable</td>
<td>40% coinsurance with minimum &amp; maximum/prescription: $10 minimum &amp; $100 maximum (retail), $20 minimum &amp; $200 maximum (mail order)</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-preferred brand drugs</td>
<td>Not applicable</td>
<td>40% coinsurance with minimum &amp; maximum/prescription: $10 minimum &amp; $100 maximum (retail), $20 minimum &amp; $200 maximum (mail order)</td>
<td>Not applicable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>Not applicable</td>
<td>Applicable cost as noted above for generic or brand drugs</td>
<td>Not applicable</td>
<td></td>
<td></td>
<td>Precertification required for coverage.</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>Not applicable</td>
<td>10% coinsurance</td>
<td>Not applicable</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Not applicable</td>
<td>10% coinsurance</td>
<td></td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>Not applicable</td>
<td>10% coinsurance after $150 copay/visit, deductible doesn't apply</td>
<td>Not applicable</td>
<td>10% coinsurance after $150 copay/visit, deductible doesn't apply</td>
<td>40% coinsurance after $150 copay/visit, deductible doesn't apply</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>Not applicable</td>
<td>10% coinsurance</td>
<td>Not applicable</td>
<td></td>
<td>Non-emergency transport: not covered, except if pre-authorized.</td>
</tr>
</tbody>
</table>

*Note: Deductible doesn't apply for non-emergency use.*
<table>
<thead>
<tr>
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<th>Services You May Need</th>
<th>Aexcel Designated Provider (You will pay the least)</th>
<th>Network Provider (You will pay more)</th>
<th>Aexcel Non-Designated Provider (You will pay the most)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent care</td>
<td>Not applicable</td>
<td>$15 copay/visit, deductible doesn't apply</td>
<td>Not applicable</td>
<td>40% coinsurance</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Facility fee (e.g., hospital room)</td>
<td>Not applicable</td>
<td>10% coinsurance after $200 copay/stay, deductible doesn't apply</td>
<td>Not applicable</td>
<td>40% coinsurance after $200 copay/stay, deductible doesn't apply</td>
<td>Pre-authorization required for out-of-network care.</td>
<td></td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>Not applicable</td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Outpatient services</td>
<td>Office &amp; other outpatient services: $15 copay/visit, deductible doesn't apply</td>
<td>Not applicable</td>
<td>Office &amp; other outpatient services: 40% coinsurance</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Inpatient services</td>
<td>Not applicable</td>
<td>10% coinsurance after $200 copay/stay, deductible doesn't apply</td>
<td>Not applicable</td>
<td>40% coinsurance after $200 copay/stay, deductible doesn't apply</td>
<td>Pre-authorization required for out-of-network care.</td>
<td></td>
</tr>
<tr>
<td>Office visits</td>
<td>$15 copay/visit, deductible doesn't apply; 10% coinsurance for all other services</td>
<td>$15 copay/visit, deductible doesn't apply; 10% coinsurance for all other services</td>
<td>Not applicable</td>
<td>40% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childbirth/delivery professional services</td>
<td>Not applicable</td>
<td>10% coinsurance</td>
<td>Not applicable</td>
<td>40% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childbirth/delivery facility services</td>
<td>Not applicable</td>
<td>10% coinsurance after $200 copay/stay, deductible doesn't apply; copay waived for newborn hospital expenses</td>
<td>Not applicable</td>
<td>40% coinsurance after $200 copay/stay, deductible doesn't apply; copay waived for newborn hospital expenses</td>
<td>If your plan is subject to health care reform law, there will be no charge for in-network preventive prenatal care. Pre-authorization required for out-of-network care may apply.</td>
<td></td>
</tr>
</tbody>
</table>

Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Aexcel Designated Provider (You will pay the least)</th>
<th>Network Provider (You will pay more)</th>
<th>Aexcel Non-Designated Provider (You will pay more)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>Not applicable</td>
<td>10% coinsurance</td>
<td>Not applicable</td>
<td>40% coinsurance</td>
<td>130 visits/calendar year. Pre-authorization required for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>Not applicable</td>
<td>$15 copay/visit, deductible doesn’t apply</td>
<td>Not applicable</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Not applicable</td>
<td>$15 copay/visit, deductible doesn’t apply</td>
<td>Not applicable</td>
<td>40% coinsurance</td>
<td>Limited to treatment of developmental delays.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>Not applicable</td>
<td>10% coinsurance after $200 copay/visit, deductible doesn’t apply</td>
<td>Not applicable</td>
<td>40% coinsurance after $200 copay/visit, deductible doesn’t apply</td>
<td>120 days/calendar year. Pre-authorization required for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>Not applicable</td>
<td>10% coinsurance</td>
<td>Not applicable</td>
<td>40% coinsurance</td>
<td>Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse. Pre-authorization required for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>Not applicable</td>
<td>10% coinsurance</td>
<td>Not applicable</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered.</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered.</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered.</td>
</tr>
</tbody>
</table>

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
- Routine eye care (Adult & Child)
- 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 - 20 visits/calendar year.
- Bariatric surgery - Limited to Institutes of Quality contracted facility for in-network only.
- Chiropractic care - 20 visits/calendar year.
- Hearing aids - 1 hearing aid to $1,000 maximum per ear/36 months.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

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 1-877-292-2480.
- 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: https://www.dol.gov/agencies/ebsa
- 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.
- 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 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 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:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-877-292-2480.
- 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 https://www.dol.gov/agencies/ebsa
- 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 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.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

-------------------To see examples of how this plan might cover costs for a sample medical situation, see the next section.-------------------
About these Coverage Examples:

**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: 1-877-292-2480.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan’s overall deductible** $100
- **Specialist copayment** $15
- **Hospital (facility) coinsurance** 10%
- **Other coinsurance** 10%

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)*

**Total Example Cost** $12,800

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$100</td>
</tr>
<tr>
<td>Copayments</td>
<td>$60</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,200</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions $60

The total Peg would pay is $1,420

### Managing Joe’s type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan’s overall deductible** $100
- **Specialist copayment** $15
- **Hospital (facility) coinsurance** 10%
- **Other coinsurance** 10%

This EXAMPLE event includes services like:
- Primary care physician office visits *(including disease education)*
- Diagnostic tests *(blood work)*
- Prescription drugs
- Durable medical equipment *(glucose meter)*

**Total Example Cost** $7,400

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$100</td>
</tr>
<tr>
<td>Copayments</td>
<td>$900</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$10</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions $20

The total Joe would pay is $1,030

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

- **The plan’s overall deductible** $100
- **Specialist copayment** $15
- **Hospital (facility) coinsurance** 10%
- **Other coinsurance** 10%

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** $1,900

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$100</td>
</tr>
<tr>
<td>Copayments</td>
<td>$80</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$100</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions $0

The total Mia would pay is $280

The plan would be responsible for the other costs of these EXAMPLE covered services.
**Assistive Technology**

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-877-292-2480.

**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 discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides 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: PO Box 24030 Fresno, CA 93779),

1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705),

Email: 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 (Aetna).
TTY: 711

**Language Assistance:**

For language assistance in your language call 1-877-292-2480 at no cost.

- **Albanian** - Për asistencë në gjihën shqipe telefononi falas në 1-877-292-2480.
- **Amharic** - እንግ%A5ላት እንчёт እንõርዋዐ እ 1-877-292-2480 ያሌ ዋ.ላ trä-
- **Arabic** - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-877-292-2480.
- **Armenian** - Լեզվի գործարարությունը (հայերեն) զարգացնե 1-877-292-2480 կատարել գույն:
- **Bahasa Indonesia** - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-877-292-2480 tanpa dikenakan biaya.
- **Bantu-Kirundi** - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-877-292-2480 ku busa
- **Bengali-Bangala** - বাংলা ভাষার সহায়তার জন্য বিনামূল্যে 1-877-292-2480-তে কল করুন।
- **Bisayan-Visayan** - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-877-292-2480 nga walay bayad.
- **Burmese** - မြန့်မည်မှာကို 1-877-292-2480 ကြည့်ပါ။
- **Catalan** - Per rebrer assistència en (català), truqui al número gratuït 1-877-292-2480.
- **Chamorro** - Para ayuda gi fino' (Chamoru), ågang 1-877-292-2480 sin gástu.
- **Cherokee** - ᯏerokee ᠲPes건설 weer. She ispeų SiT (GWV) صلةواجب 1-877-292-2480 OJOT L AGedI JEGR.I 1HFO.θ
- **Chinese** - 欲取得繁體中文語言協助, 請撥打 1-877-292-2480，無需付費。
- **Choctaw** - (Chahta) anumpa ya apela a chi l paya hinla 1-877-292-2480.
- **Cushite** - Gargaarsa afana Oromiffa hiikuu argachuuf lakkkokkofs bilbilaa 1-877-292-2480 irratti bilisanaa bilbilaa.
- **Dutch** - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-877-292-2480.
- **French** - Pour une assistance linguistique en français appeler le 1-877-292-2480 sans frais.
- **French Creole** - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-877-292-2480 gratis.
- **Greek** - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-877-292-2480 χωρίς χρέωση.
- **Gujarati** - ગુજરાતીમાં લાગે માંસ માંડી પણ અસર વગર 1-877-292-2480 પર કોલ કરો.

Hindi - हिन्दी में भाषा सहायता के लिए, 1-877-292-2480 पर मुफ्त कॉल करें।

Hmong - Maka enyemaka asusu na Igbo kpo 1-877-292-2480 na akwughig wagerq yo bula

Ibo - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-877-292-2480 nga awan ti bayadanyo.

Ilocano - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-877-292-2480.

Japanese - 日本語で援助をご希望の方は、1-877-292-2480まで無料でお電話ください。

Karen - Be’m ke gbo-ka-pa dyi pidji qe Basoo-wuqun wée, dà 1-877-292-2480

Kurdish - برای راهنمایی به زبان فارسی با شماره 1-877-292-2480 یک تماس بگیرید.

Kurmanj - Ñan bök jipa ilo Kajin Majol, kallok 1-877-292-2480 ilo ejelok wónán.

Laotian - 1-877-292-2480 kramaakawarkohntaayee hëxëshëviyêkoulkara.

Marathi - तीलभाषा (मराठी) सहाय्यासाठी 1-877-292-2480 क्रमांकावरकोणत्याहीखर्ााशिवायकॉलकरा.

Marxallest - Ñan bök jipa ilo Kajin Majol, kallok 1-877-292-2480 ilo ejelok wónán.

Micronesian- Pohnpeyan - Ohng palien sawas en soum kawewe ni omw lokaia Ponape koahl 1-877-292-2480 ni sohte isais.


Navajo - T'áá shi shaad k'ehjí bee shiká a'oodowol nínízingo Diné k'ehjí koji' t'áá jíik'e hólne' 1-877-292-2480

Nepali - (लेपाली) मा निशुल्क भाषा सहायता पाउनका लागि 1-877-292-2480 मा फोन गर्नुहोस्।

Nilo-Dinka - Tën kuoony é thok é Thuonjän cöl 1-877-292-2480 kecin ayóc.

Norwegian - For språkassistance på norsk, ring 1-877-292-2480 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਵਿਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-877-292-2480 ਵੇਲ ਕੌਲ ਵੇਲੇ।


Persian - برای راهنمایی به زبان فارسی با شماره 1-877-292-2480 یک تماس بگیرید.

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-877-292-2480.

Polynesian - Pohnpeian 1-877-292-2480 ni sohte isais.
Para obter assistência linguística em português ligue para o 1-877-292-2480 gratuitamente.

Pentru asistență lingvistică în română telefonați la numărul gratuit 1-877-292-2480.

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-877-292-2480.

Mo fesoasoani tau gagana le Gagana Samoa vala’au le 1-877-292-2480 e aunoa ma se totogi.

Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-877-292-2480.

Para obtener asistencia lingüística en español, llame sin cargo al 1-877-292-2480.

Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-877-292-2480. Njodi woo fawaaki on.

Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-877-292-2480 bila malipo.

Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-877-292-2480 nang walang bayad.

భాషతో సాయం కొరకు ఎలాంటి ఖరచులేకుండా 1-877-292-2480 కు కాల్ చేయండి. (తెలుగు)

สำหรับความช่วยเหลือทางภาษาเป็น ภาษาไทย โทร 1-877-292-2480 ฟรีไม่มีค่าใช้จ่าย


Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-877-292-2480 nge esapw kamé ngonuk.

(Dil) çağrısı dil yardım için. Hiçbir ücret ödedemen 1-877-292-2480.

Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-877-292-2480.

ا مهيكل كنست م ريب 1-877-292-2480 دهم خاپی م ايه میں در م ور ی

Để được hỗ trợ ngôn ngữ (ngôn ngữ), hãy gọi miễn phí đến số 1-877-292-2480.

फरा श्यापरा हियला आन अजिश होतात. 1-877-292-2480 परिचालना.

Fún iránlọwọ nípa èdè (Yorùbá) pe 1-877-292-2480 lái san owó kankan rará.