### Important Questions | Answers | Why This Matters:
--- | --- | ---
**What is the overall deductible?** | In-Network: Individual $100 / Family $300. Out-of-Network: Individual $450 / Family $1,350. | 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.

**Are there services covered before you meet your deductible?** | Yes. Emergency care & inpatient hospital services; plus in-network office visits, prescription drugs & preventive care are covered before you meet your deductible. | This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply.

**Are there other deductibles for specific services?** | No. | You don’t have to meet deductibles for specific services.

**What is the out-of-pocket limit for this plan?** | In-Network: Individual $2,000 / Family $4,000. Out-of-Network: Individual $3,000 / Family $6,000. Prescription drugs: Individual $1,200 / Family $3,600. | 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.

**What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges & health care this plan doesn’t cover. | Even though you pay these expenses, they don’t count toward the out-of-pocket limit.

**Will you pay less if you use a network provider?** | Yes. See www.aetna.com/docfind or call 1-800-370-4526 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan’s network. 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.

**Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral.
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>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>$15 copay/visit, deductible doesn’t apply</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$15 copay/visit, deductible doesn’t apply; 10% coinsurance for all other services</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>Not covered, except 40% coinsurance for mammograms &amp; gynecological exams</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>10% coinsurance</td>
<td>You may have to pay for services that aren’t preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic drugs</td>
<td>30% coinsurance with minimum &amp; maximum/prescription, deductible doesn’t apply: $10 minimum &amp; $100 maximum (retail), $20 minimum &amp; $200 maximum (mail order)</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 [www.aetnapharmacy.com/standard](http://www.aetnapharmacy.com/standard).
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay In-Network Designated Provider (You will pay the least)</th>
<th>Non-Designated Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred brand drugs</td>
<td>40% coinsurance with minimum &amp; maximum/ prescription, deductible doesn't apply: $10 minimum &amp; $100 maximum (retail), $20 minimum &amp; $200 maximum (mail order)</td>
<td>Not covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-preferred brand drugs</td>
<td>40% coinsurance with minimum &amp; maximum/ prescription, deductible doesn't apply: $10 minimum &amp; $100 maximum (retail), $20 minimum &amp; $200 maximum (mail order)</td>
<td>Not covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>Applicable cost as noted above for generic or brand drugs</td>
<td>Not covered</td>
<td></td>
<td>Precertification required for coverage.</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care</td>
<td>10% coinsurance after $150 copay/visit, deductible doesn't apply</td>
<td>10% coinsurance after $150 copay/visit, deductible doesn't apply</td>
<td>40% coinsurance after $150 copay/visit, deductible doesn't apply for non-emergency use.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
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<td>--------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>In-Network Designated Provider (You will pay the least)</td>
<td>Non-Designated Out-of-Network Provider (You will pay the most)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td>Non-emergency transport: not covered, except if pre-authorized.</td>
<td></td>
</tr>
<tr>
<td>Urgent care</td>
<td>$15 copay/visit, deductible doesn't apply</td>
<td>10% coinsurance after $200 copay/visit, deductible doesn't apply</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility fee (e.g., hospital room)</td>
<td>10% coinsurance after $200 copay/visit, deductible doesn't apply</td>
<td>40% coinsurance after $200 copay/visit, 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>10% coinsurance</td>
<td>40% coinsurance</td>
<td>Pre-authorization required for out-of-network care.</td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Office: $15 copay/visit, deductible doesn't apply</td>
<td>Office &amp; other outpatient services: no charge</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Outpatient services</td>
<td>10% coinsurance after $200 copay/visit, deductible doesn't apply</td>
<td>40% coinsurance after $200 copay/visit, deductible doesn't apply</td>
<td>Pre-authorization required for out-of-network care.</td>
<td></td>
</tr>
<tr>
<td>Inpatient services</td>
<td>10% coinsurance after $200 copay/visit, deductible doesn't apply</td>
<td>40% coinsurance after $200 copay/visit, deductible doesn't apply</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Office visits</td>
<td>$15 copay/visit, deductible doesn't apply</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Office visits</td>
<td>40% coinsurance</td>
<td>Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) 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>
<td></td>
</tr>
<tr>
<td>Childbirth/delivery professional services</td>
<td>10% coinsurance after $200 copay/visit, deductible doesn't apply</td>
<td>40% coinsurance after $200 copay/visit, deductible doesn't apply</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childbirth/delivery facility services</td>
<td>10% coinsurance after $200 copay/visit, deductible doesn't apply; copay waived for newborn hospital expenses</td>
<td>40% coinsurance after $200 copay/visit, deductible doesn't apply; copay waived for newborn hospital expenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay In-Network Designated Provider (You will pay the least)</td>
<td>What You Will Pay Non-Designated Out-of-Network Provider (You will pay the most)</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>-----------------------</td>
<td>----------------------</td>
<td>-------------------------------------------------</td>
<td>-------------------------------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>10% coinsurance</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>$15 copay/visit, deductible doesn't apply</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$15 copay/visit, deductible doesn't apply</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>10% coinsurance after $200 copay/stay, deductible doesn't apply</td>
<td>40% coinsurance after $200 copay/stay, 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>10% coinsurance</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>10% coinsurance</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>
</tr>
<tr>
<td></td>
<td>Children's glasses</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>
</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 for disease, injury, & chronic pain.
- Bariatric surgery - Limited to Institutes of Quality contracted facility only.
- Chiropractic care - 20 visits/calendar year.
- Hearing aids - 1 hearing aid to $1,000 maximum per ear/36 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
- Non-emergency care when traveling outside the U.S.

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.
- 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 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 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:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your 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? 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:**

*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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe’s Type 2 Diabetes</th>
<th>Mia’s Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(9 months of in-network pre-natal care and a hospital delivery)</strong></td>
<td><strong>(a year of routine in-network care of a well-controlled condition)</strong></td>
<td><strong>(in-network emergency room visit and follow up care)</strong></td>
</tr>
<tr>
<td>The plan’s overall deductible</td>
<td>$100</td>
<td>The plan’s overall deductible</td>
</tr>
<tr>
<td>Specialist copayment</td>
<td>$15</td>
<td>Specialist copayment</td>
</tr>
<tr>
<td>Hospital (facility) coinsurance</td>
<td>10%</td>
<td>Hospital (facility) coinsurance</td>
</tr>
<tr>
<td>Other coinsurance</td>
<td>10%</td>
<td>Other coinsurance</td>
</tr>
</tbody>
</table>

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: $12,700

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$100</td>
</tr>
<tr>
<td>Copayments</td>
<td>$10</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,100</td>
</tr>
</tbody>
</table>

What isn’t covered
- Limits or exclusions $60

The total Peg would pay is $1,270

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

Total Example Cost: $5,600

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$100</td>
</tr>
<tr>
<td>Copayments</td>
<td>$700</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

What isn’t covered
- Limits or exclusions $20

The total Joe would pay is $820

This EXAMPLE event includes services like:
- Emergency room care *(including medical supplies)*
- Diagnostic test *(x-ray)*
- Durable medical equipment *(crutches)*
- Rehabilitation services *(physical therapy)*

Total Example Cost: $2,800

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></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>$200</td>
</tr>
</tbody>
</table>

What isn’t covered
- Limits or exclusions $0

The total Mia would pay is $380

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 866-393-0002.

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

**Non-Discrimination**
Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

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

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

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates.
TTY: 711

Language Assistance:

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

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-800-370-4526.
Amharic - እምር ከም ከ ከምም ከ 1-800-370-4526 በተ, ይህ ወጥፋት.
Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-370-4526.
Armenian - Կենսակորեական պատկերազարդ պահանջանք (հայերեն) կապեր 1-800-370-4526 անվճեց գումար;
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 numero 1-800-370-4526 ku busa
Bengali-Bangala - বাংলাদেশের ভাষাসহায়তার জন্য বিনামূল্যে 1-800-370-4526-তে কল করুন।
Bisayan-Visayan - Alang sa pag-abag sa pinulongang sa (Binisayang Sinugboanon) tawag sa 1-800-370-4526 nga walay bayad.
Burmese - သို့ပေး (အီရှိ) လိုက်လျာ, ကျွန်ုပ်တို့ ဗိမာန် 1-800-370-4526 နှင့် ကစ်မှုနောက်ခံ ၃၇၀၅ စီးပွားရေး၏ အသေးစိတ်များ ကျွန်ုပ်တို့၏ အသေးစိတ်များ
Catalan - Per rebrer assistència en (català), truqui al número gratuït 1-800-370-4526.
Chamorro - Para ayuda gi fino' (Chamoru), ãgang 1-800-370-4526 sin gästu.
Cherokee - ᎠᏔᏨᏧᎦ ᎠᏧᎦ, ᎠᏩᏧᎦ, ᎠᏩᏧᏨ ᎪᏧᏨ (GWY) ᎠᏧᏨ'18 1-800-370-4526 ᎨᏧᏨ ᎪᏧᏨ JEGᏧᏨ I ᏧᏧᏨ.
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 hiikuur argachuuf lakkokkofsaa bilbilaa 1-800-370-4526 irratti bilisaan bilbilaa.
Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-370-4526.
French - Pour une assistance linguistique en français appeler le 1-800-370-4526 sans frais.
French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-370-4526 gratis.
German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-370-4526 an.
Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-370-4526 χωρίς χρέωση.
Gujarati - ગુજરાતીમાં ભાષામાં સહાય માટે કોઇ પણ અર્થ 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 asụsụ na Igbo kpọọ 1-800-370-4526 na akwughị ụgwọ ọ bula
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, puó 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 - လင်ဘာသာ ဗိုလ်ချုပ်မှူး များ နေရာမှာ 1-800-370-4526 ဖြစ်သည်။
Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-370-4526 번으로 전화해 주십시오.
Kru-Bassa - Be m'ke gbo-kpá-kpá dyé pidyí de Básco-wuquin we, ɖá 1-800-370-4526
Kurdish - برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 به خورايی پایه‌مندی بکن.
Laotian - ຜ່ານຍາກາ ແລະໍ້ມ ທ່ານ ມ່າ 1-800-370-4526 ຕໍ່ ມະຫາວິທະຍາ ຕັ້ງ ມະຫາວິທະຍາ, 1-800-370-4526 ແມ່ ປະຍາທິດ ໄດ້.
Marathi - कोणत्याही शुल्कशार्य भाषा सेवा प्राप्त करण्यासाठी, 1-800-370-4526 वर फोन करा.
Marshallese - Nān bōk jipañ ilo Kajin Majol, kallok 1-800-370-4526 ilo ejejok wōnān.
Micronesian - Ohng palien sawas en soun kawewē ni omw lokaia Ponape koahl 1-800-370-4526 ni sohte isais.
Mon-Khmer, Cambodian - ប្រមាណមួយនាក់ដីត្តូរប្រមាណ 1-800-370-4526 មកដាក់សេវាភិបាល។
Navajo - T'áá shi shizaad k'ehjí bee shiká a'dowol nínízingo Diné k'ehjí koi' t'áá jiík'e hólne' 1-800-370-4526
Nepali - (नेपाली) मा नि:शुल्क भाषा सहायता पाउनका लागि 1-800-370-4526 मा फोन गर्नुहोस्।
Nilotic-Dinka - Tēn kućony ę thok ě Thuojjāŋ col 1-800-370-4526 kećin ayóc.
Norwegian - For språkassistansen på norsk, ring 1-800-370-4526 kostnadsfritt.
Panjabi - ਪਾਣਾਧੀ ਹੰਡਾ ਧਾਰਕੀ ਮਾਰਗੀ ਲਾਗੀ, 1-800-370-4526 ਲੇ ਕੁਹਤਰ ਵੱਲ ਵੇਲੀ।
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 آی 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 româneste telefonați la numărul gratuit 1-800-370-4526
To get help from a Russian-speaking translator, call the free number 1-800-370-4526.

To get help from a Samoan speaker, call the free number 1-800-370-4526.

For Serbo-Croatian, call 1-800-370-4526 for free assistance.

Spanish: For linguistic assistance in Spanish, call 1-800-370-4526.

For Sudanic-Fulfude, call 1-800-370-4526 to talk.

For Swahili, get help in the Swahili language by calling 1-800-370-4526 without charge.

For Syrian, call 1-800-370-4526 for help without charge.

For Tagalog, call 1-800-370-4526 without charge for assistance.

For Telugu, get help in Telugu by calling 1-800-370-4526.

For Thai, get help in Thai by calling 1-800-370-4526 without charge.

For Tongan, call 1-800-370-4526 for assistance.

For Trukese, please call 1-800-370-4526.

For Turkish, call 1-800-370-4526 without charge for help in the Turkish language.

For Ukrainian, get help by calling 1-800-370-4526 without charge.

For Urdu, get assistance by calling 1-800-370-4526.

For Vietnamese, you can get help by calling 1-800-370-4526.

For Yiddish, call 1-800-370-4526 for assistance.

For Yoruba, get help in Yoruba by calling 1-800-370-4526.