



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>	\$0. Standard Savings: Individual \$1,500 / Family \$3,000.	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> 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>	Maximum Savings: Individual \$2,500 / Family \$5,000. Standard Savings: Individual \$4,500 / Family \$9,000. Rx Maximum: Individual \$1,351 / Family \$2,702	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> , <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> .
<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 Maximum Savings providers.	You pay the least if you use a <u>provider</u> in Maximum Savings. You pay more if you use a <u>provider</u> in Standard Savings. 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.
<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
		Maximum Savings (You will pay the least)	Standard Savings (You will pay more)	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	\$5 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not covered	None
	<u>Specialist</u> visit	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not covered	None
	<u>Preventive care /screening</u> /immunization	No charge	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 for Office, Independent Laboratory. \$15 <u>copay</u> per visit for Outpatient Hospital.	No charge for Office, Independent Laboratory. <u>Deductible</u> does not apply. 20% <u>coinsurance</u> for Outpatient Hospital.	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$15 <u>copay</u> per visit for Outpatient Hospital.	20% <u>coinsurance</u> ; for Outpatient Hospital	Not covered	None
If you need drugs to treat your illness or condition	Generic drugs	\$7 copay retail; \$18 copay mail order	In-Network copays apply. You are responsible for any charges above the allowed amount.	Not covered	30-days supply retail. Up to 90-days supply through mail order.
	Preferred brand drugs	\$16 copay retail; \$40 copay mail order		Not covered	

Common Medical Event	Services You May Need	Maximum Savings (You will pay the least)	Standard Savings (You will pay more)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
More information about <u>prescription drug coverage</u> is available at <a href="https://www.express-scripts.com/">https://www.express-scripts.com/</a>	Non-preferred brand drugs	\$35 copay retail \$88 copay mail order		Not covered	
	<u>Specialty drugs</u>	Same as retail	Not covered	Not covered	Specialty medications must be filled through Accredo Specialty Pharmacy
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$150 <u>copay</u> per visit for Ambulatory Surgical Center and Outpatient Hospital.	20% <u>coinsurance</u> for Ambulatory Surgical Center, Outpatient Hospital.	Not covered	None
	Physician/surgeon fees	No charge for Ambulatory Surgical Center, Outpatient Hospital.	20% <u>coinsurance</u> for Ambulatory Surgical Center, Outpatient Hospital.	Not covered	None
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$100 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$100 <u>copay</u> /visit, <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>	No charge	No charge. <u>Deductible</u> does not apply.	Not covered	Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$150 <u>copay</u> /stay, <u>deductible</u> doesn't apply	20% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	No charge	20% <u>coinsurance</u>	Not covered	None

Common Medical Event	Services You May Need	Maximum Savings (You will pay the least)	Standard Savings (You will pay more)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$15 <u>copay</u> per visit for Office and Outpatient Hospital	\$30 <u>copay</u> per visit for Office. <u>Deductible</u> does not apply. 20% <u>coinsurance</u> for Outpatient Hospital.	Not covered	None
	Inpatient services	No charge	20% <u>coinsurance</u>	Not covered	None
<b>If you are pregnant</b>	Office visits	\$5 <u>copay</u> per visit for Office. \$15 <u>copay</u> per visit for Office; Specialist.	\$20 <u>copay</u> per visit for Office. \$30 <u>copay</u> per visit for Office; Specialist. <u>Deductible</u> does not apply.	Not covered	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge for Inpatient Hospital	20% <u>coinsurance</u> for Inpatient Hospital	Not covered	
	Childbirth/delivery facility services	No charge for Inpatient Hospital.	20% <u>coinsurance</u> for Inpatient Hospital	Not covered	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	\$5 <u>copay</u>	\$5 <u>copay</u> . <u>Deductible</u> does not apply.	Not covered	None
	<u>Rehabilitation services</u>	\$150 <u>copay</u> per admission for Inpatient Facility. \$15 <u>copay</u> per visit for Outpatient Facility. \$5 <u>copay</u> per visit for Office.	20% <u>coinsurance</u> for Inpatient and Outpatient Facility.	Not covered	30 visits/calender year for Physical, Occupational & Speech Therapy.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
If your child needs dental or eye care	<u>Habilitation services</u>	\$150 <u>copay</u> per admission for Inpatient Facility. \$15 <u>copay</u> per visit for Outpatient Facility. \$5 <u>copay</u> per visit for Office.	20% <u>coinsurance</u> for Inpatient and Outpatient Facility.	Not covered	None
	<u>Skilled nursing care</u>	\$150 <u>copay</u> per admission for Inpatient Facility.	20% <u>coinsurance</u> for Inpatient Facility.	Not covered	In-Network inpatient skilled nursing facility days are limited to 100 days.
	<u>Durable medical equipment</u>	No charge	No charge	Not covered	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	No charge for Inpatient Facility.	\$150 <u>copay</u> per admission and 20% <u>coinsurance</u> for Inpatient Facility.	Not covered	None
	Children's eye exam	No charge	No charge. <u>Deductible</u> does not apply	Not covered	1 routine eye exam/calendar year.
	Children's glasses	Not covered	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	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.
- Bariatric surgery
- Chiropractic care - 25 visits/calendar year.
- 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 - 30 visits/calendar year.
- Routine eye care (Adult) - 1 routine eye exam/calendar year.

**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>	\$15
■ <u>Hospital (facility) copayment</u>	\$150
■ <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>	\$200
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$70
<b>The total Peg would pay is</b>	<b>\$270</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>	\$15
■ <u>Hospital (facility) copayment</u>	\$150
■ <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>	\$100
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$4,300
<b>The total Joe would pay is</b>	<b>\$4,400</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>	\$15
■ <u>Hospital (facility) copayment</u>	\$150
■ <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>	\$0
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$10
<b>The total Mia would pay is</b>	<b>\$110</b>

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

859196-751660-592001

Page 8 of 8

## 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 companies, including Aetna Life Insurance Company and its affiliates (Aetna).**

TTY: 711

**Language Assistance:**

To access language services at no cost to you, call 1-800-370-4526.

Albanian -	Për shërbime përkthimi falas për ju, telefononi 1-800-370-4526.
Amharic -	የኢትዮጵያ አገልግሎቶችን የለከናዸ ለማግኘት በ 1-800-370-4526 ይደውሉ::
Arabic -	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء التصال 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 বিনামূলক ভাষা পরিক্ষা প্রক্রিয়া প্রক্রিয়া কর্তৃত করে এই নম্বরের প্রেসিডেন্সি নম্বরে: 1-888-982-3861।
Bisayan-Visayan -	Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-800-370-4526.
Burmese -	သနိုင်းအော်မြန်မာ အခေါ်ကုန်း၏၆၆၆ မေးရပါ ဘာသာစကားဝန်ဆောင်းမား ရနိုးစိန့် 1-800-370-4526 ထို့စ ဖုန်းဝေခဲ့စွဲပါ။
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 -	GEONDAI SEOHOMONDAI OG'HESE'LA L AGONDA JGEGWLA JAY, OG'HEWOM' 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 સેંચિયની પહોર માટે, કોલ કરો 1-800-370-4526.

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 कक्सी 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 ọru gasị asusụ n'efu, kpọọ 1-800-370-4526
Ilocano -	Tapno maaksesyo 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 -	လာတိကမ္မန်ကြိုးအတိမာစာအတိမြေးစာတုတ္ထလာတုတ္ထမြေးအပြုလာကဘာဗုံးအိုးဘုံးနှင့် ကြိုး 1-800-370-4526 တာကုံး。
Korean -	무료 언어 서비스를 이용하려면 1-800-370-4526 번으로 전화해 주십시오.
Kru-Bassa -	ℳ dyi wuqu-dù kà kò dò bë dyi mowú nì Pídyi ní, nií, dà nòbà nià ke: 1-800-370-4526
Kurdish -	بۆ دەسپیئر اگەيشتن بە خزمەتكۆز ارى زمان بەسى تىچوون بۆ تو، پەپوەندى بىھ بە ژمارەى 1-800-370-4526
Laotian -	ເພື່ອຂັ້ນໄຂ້ງານບໍລິການພາກສາໄດລປໍ່ແລລຄ່າກັບທ່ານ, ໃຫ້ໃຫ້ທ່ານເປີ 1-888-982-3862
Marathi -	कोणत्याही शलुकालशवाय 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 -	ដីម្បីកខ្ពស់ល្អបានសេវាគម្ពោះភាសាដែលត្រូវការគ្រប់គ្រងសម្រាប់លោកអ្នក ស្តីពីក្រុរស៊ូត្រូវការអំលែក 1-888-982-3862។
Navajo -	T'áá ni nizaad k'ehji bee niká a'dooowol doo bááh ilinígóó koji' hólne' 1-800-370-4526.
Nepali -	निःशुल्क भाषा सेवा प्राप्त गर्ने 1-800-370-4526 मा टेलिफोन गर्नुहोस्।
Nilotic-Dinka -	Të koor yin wëëř de thokic ke cïn wëu kör keek tënöŋ yin. Ke cöł koc ye koc kuony ne nömba 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.

Punjabi -	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਕਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-800-370-4526 'ਤੇ ਫੋਨ ਕਰੋ।
Romanian -	Pentru a accesa gratuit serviciile de limbă, apelați 1-800-370-4526.
Russian -	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-800-370-4526.
Samoan -	Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-800-370-4526.
Serbo-Croatian -	Za besplatne prevodilačke usluge pozovite 1-800-370-4526.
Spanish -	Para acceder a los servicios de idiomas sin costo, llame al 1-800-370-4526.
Sudanic-Fulfude -	Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-800-370-4526.
Swahili -	Kupata huduma za lugha bila malipo kwako, piga 1-800-370-4526.
Syriac -	جَلِيلِيَّةِ الْمَهْمَّةِ، ١٨٠٠-٣٧٠-٤٥٢٦
Tagalog -	Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-800-370-4526.
Telugu -	మీరు భాష సేవలను ఉచితంగా అందుకునందుకు, 1-800-370-4526 కు కాల్ చేయండి.
Thai -	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-800-370-4526.
Tongan -	Kapau 'oku ke fiema'u ta'etōtōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-800-370-4526.
Trukese -	Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-800-370-4526.
Turkish -	Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-800-370-4526 numarayı arayın.
Ukrainian -	Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-800-370-4526.
Urdu -	بالقیمت زبان سے متعلق خدمات حاصل کرنے کے لیے ، 1-888-982-3862 پر بات کریں۔
Vietnamese -	Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-800-370-4526.
Yiddish -	צֹו צוֹטְרִיט שְׁפָרָאַךְ בְּאַדִּינוּנָגָעָן אַיִן קִיִּין פֿרִיעַץ צֹו אַיִר, רְופַעַן 1-800-370-4526
Yoruba -	Latí wọnú awọn isé èdè l'ofe fun o, pe 1-800-370-4526.