



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:  |
|---|---|--|
| What is the overall <u>deductible</u> ?                             | In- <u>Network</u> : EE Only \$1,600; EE+ Family: Individual \$1,600/ Family \$3,200. Out-of- <u>Network</u> : EE Only \$3,200; Family \$6,400.                       | 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. <b>In <u>Network</u>:</b> The family <u>deductible</u> is a cumulative <u>deductible</u> for all family members. The family <u>deductible</u> can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual <u>deductible</u> amount. / <b>Out of <u>Network</u>:</b> The family deductible is a cumulative deductible for all family members. The overall family <u>deductible</u> must be met by one family member or a combination of family members before the <u>plan</u> begins to pay.                    |
| Are there services covered before you meet your <u>deductible</u> ? | Yes. In- <u>network</u> office visits, <u>prescription drugs</u> & <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> .   |
| Are there other <u>deductibles</u> for specific services?           | No.   | You don't have to meet <u>deductibles</u> for specific services.   |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?       | In- <u>Network</u> : EE Only \$4,200; EE+ Family: Individual \$4,200/ Family \$8,400. Out-of- <u>Network</u> : EE Only \$8,400; Family \$16,800.                      | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. <b>In <u>Network</u>:</b> The family <u>out-of-pocket limit</u> is a cumulative <u>out-of-pocket limit</u> for all family members. The family <u>out-of-pocket limit</u> can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual <u>out-of-pocket limit</u> . / <b>Out of <u>Network</u>:</b> The family out-of-pocket maximum is a cumulative out-of-pocket limit for all family members. The overall family <u>out-of-pocket limit</u> must be met by one family member or a combination of family members before the <u>plan</u> begins to pay at 100%. |
| What is not included in the <u>out-of-pocket limit</u> ?            | <u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover & penalties for failure to obtain <u>pre-authorization</u> for services. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .   |
| Will you pay less if you use a <u>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 providers</u> .                         | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.  |
| Do you need a <u>referral</u> to see a <u>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<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most)          |  |
| If you visit a health care <u>provider's</u> office or clinic   | Primary care visit to treat an injury or illness        | \$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply  | 50% <u>coinsurance</u>                                      | None   |
|   | <u>Specialist</u> visit                                 | \$75 <u>copay</u> /visit, <u>deductible</u> doesn't apply  | 50% <u>coinsurance</u>                                      | None   |
|   | <u>Preventive care</u> / <u>screening</u> /immunization | No charge  | 50% <u>coinsurance</u> , except no charge for immunizations | 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)              | 30% <u>coinsurance</u>   | 50% <u>coinsurance</u>                                      | None   |
|   | Imaging (CT/PET scans, MRIs)                            | 30% <u>coinsurance</u>   | 50% <u>coinsurance</u>                                      | None   |
| If you need drugs to treat your illness or condition<br><br>More information about <u>prescription drug coverage</u> is available at <a href="http://www.aetnapharmacy.com/valueplus">www.aetnapharmacy.com/valueplus</a> | Generic drugs   | <u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$20 for 30 day supply, \$40 for 31-60 day supply, \$60 for 61-90 day supply (retail), \$40 (mail order)    | Not covered   | Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in- <u>network</u> . Review your <u>formulary</u> for prescriptions requiring step therapy for coverage. Your cost will be higher for choosing Brand over Generics. |
|   | Preferred brand drugs                                   | <u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$50 for 30 day supply, \$100 for 31-60 day supply, \$150 for 61-90 day supply (retail), \$100 (mail order) | Not covered   |  |

| Common Medical Event  | Services You May Need                          | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information  |
|---|--|--|--|---|
|   |  | In-Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most)         |   |
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.aetnapharmacy.com/valueplus">www.aetnapharmacy.com/valueplus</a> | Non-preferred brand drugs                      | <u>Copay/prescription, deductible</u> doesn't apply: \$75 for 30 day supply, \$150 for 31-60 day supply, \$225 for 61-90 day supply (retail), \$150 (mail order) | Not covered  | Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral fertility drugs. No charge for preferred generic FDA-approved women's contraceptives <u>in-network</u> . Review your <u>formulary</u> for prescriptions requiring step therapy for coverage. Your cost will be higher for choosing Brand over Generics.<br><br>First prescription fill at a retail pharmacy or specialty pharmacy. Subsequent fills must be through the Aetna Specialty Pharmacy <u>Network</u> . |
|   | <u>Specialty drugs</u>                         | Applicable cost as noted above for generic or brand drugs  | Not covered  |   |
| <b>If you have outpatient surgery</b>   | Facility fee (e.g., ambulatory surgery center) | 30% <u>coinsurance</u>   | 50% <u>coinsurance</u>                                     | None  |
|   | Physician/surgeon fees                         | 30% <u>coinsurance</u>   | 50% <u>coinsurance</u>                                     | None  |
| <b>If you need immediate medical attention</b>  | <u>Emergency room care</u>                     | 30% <u>coinsurance</u>   | 30% <u>coinsurance</u>                                     | No coverage for non-emergency use.<br>50% <u>coinsurance</u> for non-emergency transport.   |
|   | <u>Emergency medical transportation</u>        | 30% <u>coinsurance</u>   | 30% <u>coinsurance</u>                                     |   |
|   | <u>Urgent care</u>                             | \$75 <u>copay/visit, deductible</u> doesn't apply  | 50% <u>coinsurance</u>                                     | No coverage for non-urgent use.   |
| <b>If you have a hospital stay</b>  | Facility fee (e.g., hospital room)             | 30% <u>coinsurance</u>   | 50% <u>coinsurance</u>                                     | Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.  |
|   | Physician/surgeon fees                         | 30% <u>coinsurance</u>   | 50% <u>coinsurance</u>                                     | None  |
| <b>If you need mental health, behavioral health, or substance abuse services</b>  | Outpatient services                            | Office: \$75 <u>copay/visit, deductible</u> doesn't apply; other outpatient services: no charge  | Office & other outpatient services: 50% <u>coinsurance</u> | None  |
|   | Inpatient services                             | 30% <u>coinsurance</u>   | 50% <u>coinsurance</u>                                     | Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.  |

| Common Medical Event   | Services You May Need                     | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information   |
|--|---|---|--|--|
|  |   | In-Network Provider<br>(You will pay the least)           | Out-of-Network Provider<br>(You will pay the most) |  |
| If you are pregnant  | Office visits                             | No charge   | 50% <u>coinsurance</u>                             | <u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply. |
|  | Childbirth/delivery professional services | 30% <u>coinsurance</u>                                    | 50% <u>coinsurance</u>                             |  |
|  | Childbirth/delivery facility services     | 30% <u>coinsurance</u>                                    | 50% <u>coinsurance</u>                             |  |
| If you need help recovering or have other special health needs | <u>Home health care</u>                   | 30% <u>coinsurance</u>                                    | 50% <u>coinsurance</u>                             | 60 visits/calendar year. Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.  |
|  | <u>Rehabilitation services</u>            | \$75 <u>copay</u> /visit, <u>deductible</u> doesn't apply | 50% <u>coinsurance</u>                             | 60 visits/calendar year for Physical, Occupational & Speech Therapy combined, including outpatient hospital services. Includes treatment of Autism & <u>habilitation services</u> .  |
|  | <u>Habilitation services</u>              | \$75 <u>copay</u> /visit, <u>deductible</u> doesn't apply | 50% <u>coinsurance</u>                             |  |
|  | <u>Skilled nursing care</u>               | 30% <u>coinsurance</u>                                    | 50% <u>coinsurance</u>                             | 60 days/calendar year. Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.  |
|  | <u>Durable medical equipment</u>          | 30% <u>coinsurance</u>                                    | 50% <u>coinsurance</u>                             | Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.   |
|  | <u>Hospice services</u>                   | 30% <u>coinsurance</u>                                    | 50% <u>coinsurance</u>                             | Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.   |
| If your child needs dental or eye care                         | Children's eye exam                       | Not covered   | Not covered  | Not covered.   |
|  | 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.
- Private-duty nursing
- 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 - 30 visits/calendar year.
- Bariatric surgery
- Chiropractic care - 30 visits/calendar year.
- Hearing aids - 1 hearing aid per ear/36 months.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.

## 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 : <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](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 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 <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](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.**

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:



**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 plan's overall deductible \$1,600
- Specialist copayment \$75
- Hospital (facility) coinsurance 30%
- Other coinsurance 30%

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>\$12,800</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$1,600        |
| Copayments                        | \$0            |
| Coinsurance                       | \$2,600        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$4,260</b> |

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

- The plan's overall deductible \$1,600
- Specialist copayment \$75
- Hospital (facility) coinsurance 30%
- Other coinsurance 30%

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>\$7,400</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$100          |
| Copayments                        | \$2,200        |
| Coinsurance                       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$2,320</b> |

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

- The plan's overall deductible \$1,600
- Specialist copayment \$75
- Hospital (facility) coinsurance 30%
- Other coinsurance 30%

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>\$1,900</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$1,300        |
| Copayments                        | \$300          |
| Coinsurance                       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,600</b> |

### Assistive Technology

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

### Smartphone or Tablet

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

### Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not 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](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 (Aetna).





- Hindi - 1-800-370-4526
- 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 ugwo 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 - လာဝ်တၢ်မၤစၢၤတၢ်ကတိၤကျိၣ်အံၤကိၤ ကျိၣ် ကိး 1-800-370-4526 လာဝ်တၢ်အိၣ်ဒီးတၢ်လာဝ်ဘျၣ်လာဝ်စုၤဘျၣ်
- Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-370-4526 번으로 전화해 주십시오.
- Kru-Bassa - ʔé m'ké gbo-kpá-kpá dyé pídyi dé ʔašwó-wuḍuñ wɛɛ, dá 1-800-370-4526
- Kurdish - برائى راهنمايى به زبان فارسى با شماره 1-800-370-4526 به خورايى پييوندى بکەن.
- Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-800-370-4526 ໂດຍບໍ່ເສຍຄ່າໂທ.
- Marathi - तीलभाषा (मराठी) सहाय्यासाठी 1-800-370-4526 क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.
- Marshallese - Ñan bök 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 - សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទទេកាន់លេខ 1-800-370-4526 ដោយឥតគិតថ្លៃ។
- 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 - Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-800-370-4526 kec'in ayöc.
- Norwegian - For språkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt.
- Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-370-4526 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।
- Pennsylvania Dutch - Fer Hilfe 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 românește 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 - ܠܗܘܢܐ ܩܘܪܕܢܐ ܕܡܘܨܘܪܐ ܕܡܘܨܘܪܐ ܕܡܘܨܘܪܐ ܕܡܘܨܘܪܐ ܕܡܘܨܘܪܐ 1-800-370-4526 ܕܡܘܨܘܪܐ.
- Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-370-4526 nang walang bayad.
- Telugu - భాషలో సాయం కోరకు 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 ʻōtōngi.
- Trukese - Ren ánninnisin chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-800-370-4526 nge esapw kamé ngonuk.
- Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemedен 1-800-370-4526.
- Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-370-4526.
- Urdu - اے ری کال گفتفام رپ 1-800-370-4526 سے مل سکتے ہیں اور اس میں کوئی رقم نہیں ہے۔
- Vietnamese - Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-800-370-4526.
- Yiddish - פאר שפראך הילף אין אידיש רופט 1-800-370-4526 פון אפצאל.

Yoruba -

Fún ìrànጧwọ nípa èdè (Yorùbá) pe 1-800-370-4526 láí san owó kankan rárá.