**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage for:** Individual + Family | **Plan Type:** POS

**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **https://www.aetna.com/sbcsearch/getpolicydocs?u=070600-030020-001794** or by calling **1-800-370-4526**.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | Network: Individual **$0** / Family **$0**. Out–of–Network: Individual **$100** / Family **$250**. Does not apply to prescription drugs and emergency care. | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out-of-pocket limit on my expenses?** | Yes. Network: Individual **$400** / Family **$800**. Out–of–Network: Individual **$2,000** / Family **$5,000**. Prescription drugs: Individual **$1,320** / Family **$2,640**. | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billed charges, penalties for failure to obtain pre-authorization for service, and health care this plan does not cover. | Even though you pay these expenses, they don't count toward the **out-of pocket limit**. |
| **Is there an overall annual limit on what the plan pays?** | No. | The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. See **www.aetna.com** or call 1-800-370-4526 for a list of network **providers**. | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**. |
| **Do I need a referral to see a specialist?** | No. | You can see the **specialist** you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**. |

**Questions:** Call 1-800-370-4526 or visit us at www.HealthReformPlanSBC.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.HealthReformPlanSBC.com or call 1-800-370-4526 to request a copy.

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs **Coverage for:** Individual + Family | **Plan Type:** POS

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider | Your Cost If You Use an Out–of–Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $10 copay/visit | 20% coinsurance | Includes Internist, General Physician, Family Practitioner or Pediatrician. |
| | Specialist visit | $10 copay/visit | 20% coinsurance | ——————none—————— |
| | Other practitioner office visit | $10 copay/visit | 20% coinsurance | Coverage is limited to 30 visits per calendar year for Chiropractic care. |
| | Preventive care /screening /immunization | No charge | 20% coinsurance; deductible waived for child immunizations | Age and frequency schedules may apply. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge | 20% coinsurance | ——————none—————— |
| | Imaging (CT/PET scans, MRIs) | No charge | 20% coinsurance | ——————none—————— |

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs **Coverage for:** Individual + Family | **Plan Type:** POS

| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider | Your Cost If You Use an Out–of–Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.aetnapharmacy.com/premierplus<br><br>Premier Plus Formulary | Generic drugs | Copay/prescription: $3 for 30 day supply, $6 for 31-60 day supply, $9 for 61-90 day supply (retail); $5 for 90 day supply (mail order) | 20% coinsurance after copay/prescription: $3 for 30 day supply (retail) | Covers 90 day supply (retail & mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for formulary generic FDA-approved women's contraceptives in-network. Review your formulary for prescriptions requiring precertification for coverage. |
| | Preferred brand drugs | Copay/prescription: $10 for 30 day supply, $20 for 31-60 day supply, $30 for 61-90 day supply (retail); $15 for 90 day supply (mail order) | 20% coinsurance after copay/prescription: $10 for 30 day supply (retail) | |
| | Non-preferred brand drugs | Copay/prescription: $10 for 30 day supply, $20 for 31-60 day supply, $30 for 61-90 day supply (retail); $15 for 90 day supply (mail order) | 20% coinsurance after copay/prescription: $10 for 30 day supply (retail) | |
| | Specialty drugs | Applicable cost as noted above for generic or brand drugs. | Applicable cost as noted above for generic or brand drugs. | ——————none—————— |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No charge | 20% coinsurance | ——————none—————— |
| | Physician/surgeon fees | No charge | 20% coinsurance | ——————none—————— |
| **If you need immediate medical attention** | Emergency room services | $25 copay/visit | $25 copay/visit | No coverage for non-emergency use. |
| | Emergency medical transportation | 10% coinsurance | 10% coinsurance | 20% coinsurance for non-emergency transport. |
| | Urgent care | $10 copay/visit | 20% coinsurance | No coverage for non-urgent use. |

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs **Coverage for:** Individual + Family | **Plan Type:** POS

| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider | Your Cost If You Use an Out–of–Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No charge | 20% coinsurance | Pre-authorization required for out-of-network care. |
| | Physician/surgeon fee | No charge | 20% coinsurance | ——————none—————— |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | No charge | 20% coinsurance | ——————none—————— |
| | Mental/Behavioral health inpatient services | No charge | 20% coinsurance | Pre-authorization required for out-of-network care. |
| | Substance use disorder outpatient services | No charge | 20% coinsurance | ——————none—————— |
| | Substance use disorder inpatient services | No charge | 20% coinsurance | Pre-authorization required for out-of-network care. |
| **If you are pregnant** | Prenatal and postnatal care | No charge | 20% coinsurance | ——————none—————— |
| | Delivery and all inpatient services | No charge | 20% coinsurance | Includes outpatient postnatal care. Pre-authorization may be required for out-of-network care. |
| **If you need help recovering or have other special health needs** | Home health care | No charge | 20% coinsurance | Pre-authorization required for out-of-network care. |
| | Rehabilitation services | $10 copay/visit | 20% coinsurance | ——————none—————— |
| | Habilitation services | $10 copay/visit | 20% coinsurance | Coverage is limited to treatment of Autism. |
| | Skilled nursing care | No charge | 20% coinsurance | Coverage is limited to 120 days in-network and 60 days out-of-network per calendar year. Pre-authorization required for out-of-network care. |
| | Durable medical equipment | 10% coinsurance | 20% coinsurance | ——————none—————— |
| | Hospice service | No charge | 20% coinsurance | Pre-authorization required for out-of-network care. |
| **If your child needs dental or eye care** | Eye exam | $10 copay/visit | 20% coinsurance | Coverage is limited to 1 routine eye exam per calendar year. |
| | Glasses | Not covered | Not covered | Not covered. |

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**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs **Coverage for:** Individual + Family | **Plan Type:** POS

| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider | Your Cost If You Use an Out–of–Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Dental check-up | Not covered | Not covered | Not covered. |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for 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 (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care - Coverage is limited to 30 visits per calendar year.
- Hearing aids - Coverage is limited to 1 hearing aid to a maximum of $1,000 per ear per 24 months for children under age 16.
- Infertility treatment - Coverage is limited to the diagnosis and treatment of underlying medical condition, artificial insemination, and ovulation induction. Advanced reproductive technology limited to 4 complete egg retrievals per lifetime.
- Private-duty nursing
- Routine eye care (Adult) - Coverage is limited to 1 routine eye exam per calendar year.

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-370-4526. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or **www.dol.gov/ebsa**, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or **www.cciio.cms.gov**.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact us by calling the toll free number on your Medical ID Card. If your group health plan is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or **www.dol.gov/ebsa/healthreform**.
You may also contact the New Jersey State Insurance Department, (800) 446-7467, http://www.state.nj.us/dobi/consumer.htm
Additionally, a consumer assistance program can help you file your **appeal**. Contact New Jersey State Insurance Department, Office of Consumer Protection Services, NJ Department of Banking and Insurance, P.O. Box 329, Trenton, NJ 08625-0329, (800) 446-7467, http://www.state.nj.us/dobi/consumer.htm

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

----------*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*----------

# About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

## Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $7,330
- **Patient pays:** $210

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $0 |
| Copays | $10 |
| Coinsurance | $0 |
| Limits or exclusions | $200 |
| **Total** | **$210** |

## Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $5,020
- **Patient pays:** $380

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $0 |
| Copays | $200 |
| Coinsurance | $100 |
| Limits or exclusions | $80 |
| **Total** | **$380** |

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

## 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 on the basis of race, color, national origin, age, disability, or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aetna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 14462, Lexington, KY 40512, 1-800-648-7817, TTY 711, Fax 859-425-3379, CRCoordinator@aetna.com.

California HMO/HNO Members: Civil Rights Coordinator, PO Box 24030 Fresno CA, 93779, 1-800-648-7817, TTY 711, Fax 860-262-7705, CRCoordinator@aetna.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

**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 - | ለቋንቋ እገዛ በ አማርኛ በ 1-800-370-4526 በነጻ ይደውሉ |
| Arabic - | للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-370-4526 |
| Armenian - | Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-800-370-4526 առանց գնով: |
| Bahasa Indonesia - | Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya. |
| Bantu-Kirundi - | Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-800-370-4526 ku busa |
| Bengali-Bangala - | বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-800-370-4526-তে কল করুন। |
| Bisayan-Visayan - | Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-370-4526 nga walay bayad. |
| Burmese - | ဌာနေကျန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-800-370-4526 ကို ခေါ်ဆိုပါ။ |
| Catalan - | Per rebre assistència en (català), truqui al número gratuït 1-800-370-4526. |
| Chamorro - | Para ayuda gi fino' (Chamoru), ågang 1-800-370-4526 sin gåstu. |
| Cherokee - | ᏫᏙᎩᏫ ᏚᏳᏂᏱᏙᏗ ᏗᏂᏙᏚᏅᏙᎩ ᏫᏩᏔ (ᏣᎳᎩ) ᏭᏂᏔᏛᏚ 1-800-370-4526 ᎤᏫᏔ ᏓᏁᏙᏗ ᏧᏋᏣᏅᏗ ᏂᏥᏅᏫ. |
| 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 l paya hinla 1-800-370-4526. |
| Cushite - | Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-800-370-4526 irratti bilisaan bilbilaa. |
| Dutch - | Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-370-4526. |
| French - | Pour une assistance linguistique en français appeler le 1-800-370-4526 sans frais. |
| French Creole - | Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-370-4526 gratis. |
| German - | Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-370-4526 an. |
| Greek - | Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-370-4526 χωρίς χρέωση. |
| Gujarati - | ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-800-370-4526 પર કૉલ 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 akwụghị ụgwọ ọ bụla |
| Ilocano - | Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-370-4526 nga awan ti bayadanyo. |
| Italian - | Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-370-4526. |
| Japanese - | 日本語で援助をご希望の方は、1-800-370-4526 まで無料でお電話ください。 |
| Karen - | လၢတၢ်မၤစၢၤတၢ်ကတိၤကျိာ်အဂီၢ် ကျိာ် ကိး 1-800-370-4526 လၢတအိာ်ဒီးတၢ်လၢာ်ဘျာ်လၢာ်စ့ၤဘၣ် |
| Korean - | 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-370-4526번으로 전화해 주십시오. |
| Kru-Bassa - | Ɓɛ´m`ké gbo-kpá-kpá dyé piɗyi ɖé Ɓaɓɔɔ́-wuɖuǔn wɛɛ̃, ɖá 1-800-370-4526 |
| Kurdish - | برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 به خۆرایی پەیوەندی بکەن. |
| Laotian - | ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-800-370-4526 ໂດຍບໍ່ເສຍຄ່າໂທ. |
| Marathi - | तीलभाषा (मराठी) सहाय्यासाठी 1-800-370-4526 क्रमांकावरकोणत्याहीखर्चाशवायकॉलकरा. |
| Marshallese - | Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-370-4526 ilo ejjelok wōnān. |
| Micronesian-Pohnpeyan - | Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-370-4526 ni sohte isais. |
| Mon-Khmer, Cambodian - | សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 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 नःिशुल्क भाषा सहायता पाउनका लागि 1-800-370-4526 मा फोन गर्नुहोस् । |
| Nilotic-Dinka - | Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-800-370-4526 kecïn aɣöc. |
| Norwegian - | For språkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt. |
| Panjabi - | ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-370-4526 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ। |
| Pennsylvania Dutch - | Fer Helfe in Deitsch, ruf: 1-800-370-4526 aa. Es Aaruf koschtet nix. |
| Persian - | برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 بدون هیچ هزینه ای تماس بگیرید. انگلیسی |
| Polish - | Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-370-4526. |

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| Portuguese - | Para obter assistência linguística em português ligue para o 1-800-370-4526 gratuitamente. |
| Romanian - | Pentru asistenţă lingvistică în româneşte telefonaţi 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 heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 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 - | ܐܢ ܡܨܝܬܘܢ ܥܕܪܐ ܕܡܠܬܐ ܕܐܪܡܝܐ ܬܘܟܠܘܢ ܠܡܬܚܢܢܘܬ ܠܡܠܬܐ ܕܐܪܡܝܐ ܬܘܟܠܘܢ 1-800-370-4526 ܕܚܠܦܐ. |
| Tagalog - | Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-370-4526 nang walang bayad. |
| Telugu - | భాషతో సహాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-800-370-4526 కు కాల్ చేయండి. (తెలుగు) |
| Thai - | สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-800-370-4526 ฟรีไม่มีค่าใช้จ่าย |
| Tongan - | Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-800-370-4526 ‘o ‘ikai hā tōtōngi. |
| Trukese - | Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-800-370-4526 nge esapw kamé ngonuk. |
| Turkish - | (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-800-370-4526. |
| Ukrainian - | Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-370-4526. |
| Urdu - | اردو میں مدد کے لئے مفت 1-800-370-4526 پر کال کریں |
| Vietnamese - | Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-800-370-4526. |
| Yiddish - | פאר שפּראַך הילף אין אידיש רופט 1-800-370-4526 פריי פון אָפּצאָל. |
| Yoruba - | Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-800-370-4526 lái san owó kankan rárá. |