Coverage for: Individual + Family | Plan Type: POS



The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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, <u>www.HealthReformPlanSBC.com</u> or by calling 1-888-982-3862. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-888-982-3862 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|--|
| What is the overall <u>deductible</u> ? | In-network: \$0. Out-of-Network: Individual \$250 / Family \$750. | 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> . |
| Are there services covered before you meet your <u>deductible</u> ? | Yes. Emergency care & <u>prescription drugs</u> ; plus in- <u>network</u> office visits & <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 <u>https://www.healthcare.gov/coverage/preventive-care-benefits/</u> |
| Are there other <u>deductible</u> s for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ? | In- <u>Network</u> : Individual \$6,350 / Family \$12,700. Out-of-Network: Individual \$1,000 / Family \$3,000. | 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</u> <u>limits</u> until the overall family <u>out–of–pocket limit</u> has been met. |
| What is not included in the <u>out-of-pocket limit</u> ? | <u>Premium</u> s, <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 <u>www.aetna.com/docfind</u> or call 1-888- 982-3862 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</u> <u>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 **<u>copayment</u>** and **<u>coinsurance</u>** costs shown in this chart are after your **<u>deductible</u>** has been met, if a **<u>deductible</u>** applies.

| | | What You | u Will Pay | |
|--|--|--|--|---|
| Common Medical Event | Services You May Need | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
| If you visit a health care <u>provider</u> 's office or clinic | Primary care visit to treat an injury or illness | \$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply | 30% <u>coinsurance</u> | None |
| If you visit a health care <u>provider</u> 's office or clinic | <u>Specialist</u> visit | \$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply | 30% <u>coinsurance</u> | None |
| If you visit a health care <u>provider</u> 's office or clinic | Preventive care /screening /immunization | No charge | 30% <u>coinsurance,</u> except routine physicals & immunizations 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 | Diagnostic test (x-ray, blood work) | No charge | 30% <u>coinsurance</u> | None |
| If you have a test | Imaging (CT/PET scans, MRIs) | \$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply; no charge if performed in a Preferred Complex Radiology <u>Network</u> | 30% <u>coinsurance</u> | None |

| | | What You | ı Will Pay | |
|---|-----------------------|--|--|--|
| Common Medical Event | Services You May Need | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
| If you need drugs to treat your illness or condition More information about <u>prescription</u> <u>drug coverage</u> is available at <u>www.aetnapharmac</u> <u>y.com/advancedcon</u> <u>trol</u> | Generic drugs | <u>Copav</u> /prescription, <u>deductible</u> doesn't apply: \$10 (retail), \$20 (mail order) | 20% <u>coinsurance,</u> <u>deductible</u> doesn't apply (retail) | Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable 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; cost difference penalty doesn't apply to <u>out-of-pocket limit</u> . Maintenance drugs- no refill restrictions or penalties apply. Members save with lower <u>copays</u> at CVS Caremark® Mail Service Pharmacy or CVS Pharmacy. |
| If you need drugs to treat your illness or condition More information about <u>prescription</u> <u>drug coverage</u> is available at <u>www.aetnapharmac</u> <u>y.com/advancedcon</u> <u>trol</u> | Alternate drugs | <u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$35 (retail), \$70 (mail order) | 20% <u>coinsurance,</u> <u>deductible</u> doesn't apply (retail) | Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable 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; cost difference penalty doesn't apply to <u>out-of-pocket limit</u> . Maintenance drugs- no refill restrictions or penalties apply. Members save with lower <u>copay</u> s at CVS Caremark® Mail Service Pharmacy or CVS Pharmacy. |

| | | What You Will Pay | | | |
|---|--|---|--|--|--|
| Common Medical Event | Services You May Need | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information | |
| If you need drugs to treat your illness or condition More information about <u>prescription</u> <u>drug coverage</u> is available at <u>www.aetnapharmac</u> <u>y.com/advancedcon</u> <u>trol</u> | Non-preferred brand drugs | <u>Copav</u> /prescription, <u>deductible</u> doesn't apply: \$55 (retail), \$110 (mail order) | 20% <u>coinsurance,</u> <u>deductible</u> doesn't apply (retail) | Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable 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; cost difference penalty doesn't apply to <u>out-of-pocket limit</u> . Maintenance drugs- no refill restrictions or penalties apply. Members save with lower <u>copay</u> s at CVS Caremark® Mail Service Pharmacy or CVS Pharmacy. | |
| If you need drugs to treat your illness or condition More information about <u>prescription</u> <u>drug coverage</u> is available at <u>www.aetnapharmac</u> <u>y.com/advancedcon</u> <u>trol</u> | <u>Specialty drugs</u> | Applicable cost as noted above for generic or brand drugs | Not covered | All prescriptions must be filled through the Aetna Specialty Pharmacy <u>Network</u> . Precertification required for coverage. | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge | 30% <u>coinsurance</u> | None | |
| If you have outpatient surgery | Physician/surgeon fees | No charge | 30% <u>coinsurance</u> | None | |

| | | What You In-Network | u Will Pay Out-of-Network | |
|---|------------------------------------|---|--|---|
| Common Medical Event | Services You May Need | | | Limitations, Exceptions, & Other Important Information |
| If you need immediate medical attention | Emergency room care | \$100 <u>copay</u> /visit, <u>deductible</u> doesn't apply | \$100 <u>copay</u> /visit, <u>deductible</u> doesn't apply | Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . No coverage for non-emergency use. |
| If you need immediate medical attention | Emergency medical transportation | No charge | No charge | Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . Non-emergency transport: not covered, except if pre-authorized. |
| If you need immediate medical attention | <u>Urgent care</u> | \$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply | 30% <u>coinsurance</u> | No coverage for non-urgent use. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge | 30% <u>coinsurance</u> | Penalty of \$200 for failure to obtain <u>pre-</u> <u>authorization</u> for out-of-network care. |
| lf you have a hospital stay | Physician/surgeon fees | No charge | 30% <u>coinsurance</u> | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office & other outpatient services: \$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply | Office & other outpatient services: 30% <u>coinsurance</u> | None |
| If you need mental health, behavioral health, or substance abuse services | Inpatient services | No charge | 30% <u>coinsurance</u> | Penalty of \$200 for failure to obtain <u>pre-</u> <u>authorization</u> for out-of-network care. |
| If you are pregnant | Office visits | No charge | 30% <u>coinsurance</u> | <u>Cost sharing</u> does not apply for <u>preventive</u> <u>services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Penalty of \$200 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply. |

| | | What You | ı Will Pay | |
|---|---|---|--|---|
| Common Medical Event | Services You May Need | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
| lf you are pregnant | Childbirth/delivery professional services | No charge | 30% <u>coinsurance</u> | <u>Cost sharing</u> does not apply for <u>preventive</u> <u>services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Penalty of \$200 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply. |
| lf you are pregnant | Childbirth/delivery facility services | No charge | 30% <u>coinsurance</u> | <u>Cost sharing</u> does not apply for <u>preventive</u> <u>services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Penalty of \$200 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply. |
| If you need help recovering or have other special health needs | Home health care | No charge | 30% <u>coinsurance</u> | 120 visits/calendar year. Penalty of \$200 for failure to obtain pre-authorization for out-of-network care. |
| If you need help recovering or have other special health needs | Rehabilitation services | \$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply | 30% <u>coinsurance</u> | None |
| If you need help recovering or have other special health needs | Habilitation services | \$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply | 30% <u>coinsurance</u> | None |
| If you need help recovering or have other special health needs | Skilled nursing care | No charge | 30% <u>coinsurance</u> | 90 days/calendar year. Penalty of \$200 for failure to obtain <u>pre-authorization</u> for out-of-network care. |
| If you need help recovering or have other special health needs | Durable medical equipment | No charge | 30% <u>coinsurance</u> | Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse. |

| Common Medical Event | Services You May Need | What You In-Network Provider (You will pay the least) | u Will Pay Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|----------------------------|---|--|--|
| If you need help recovering or have other special health needs | Hospice services | No charge | 30% <u>coinsurance</u> | Penalty of \$200 for failure to obtain <u>pre-</u> authorization for out-of-network care. |
| If your child needs dental or eye care | Children's eye exam | \$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply | 30% <u>coinsurance</u> | 1 routine eye exam/12 months. |
| If your child needs dental or eye care | Children's glasses | Not covered | Not covered | Not covered. |
| If your child needs dental or eye care | Children's dental check-up | Not covered | Not covered | Not covered. |

Excluded Services & Other Covered Services:

| Cosmetic surgery Dental care (Adult & Child) | Hearing aids Long-term care | Routine foot careWeight loss programs | | |
|--|---|--|--|--|
| Dental care (Adult & Child) Glasses (Child) Non-emergency care when traveling outside the U.S. Weight loss programs | | | | |
| | | | | |
| | | | | |
| her Covered Services (Limitations may app | bly to these services. This isn't a complete list. Pleas | se see your <u>plan</u> document.) | | |
| her Covered Services (Limitations may app Acupuncture - 10 visits/calendar year for | bly to these services. This isn't a complete list. Pleas Chiropractic care | se see your <u>plan</u> document.) Private-duty nursing | | |

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:
 For more information on your rights to continue coverage, contact the plan at 1-888-982-3862.

- 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 <u>plan</u>, church <u>plans</u> 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 <u>Health Insurance Marketplace</u>. For more information about the <u>Marketplace</u>, visit <u>www.HealthCare.gov</u> or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your plan documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. 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 1-888-982-3862. 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 <u>appeal</u>. Contact information is at: <u>http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html</u>.

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 <u>plan</u> 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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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) |

\$0

\$30

\$0

\$0

| The plan's overall deductible | |
|--------------------------------------|--|
| Specialist copayment | |
| Hospital (facility) <u>copayment</u> | |
| Other <u>copayment</u> | |

This EXAMPLE event includes services like: <u>Specialist</u> office visits (*prenatal care*) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (*ultrasounds and blood work*) <u>Specialist</u> visit (*anesthesia*)

| Total Example Cost | \$12,700 |
|---------------------------------|----------|
| In this example, Peg would pay: | |
| <u>Cost Sharing</u> | |
| Deductibles | \$0 |
| <u>Copayments</u> | \$10 |
| <u>Coinsurance</u> | \$0 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$70 |

Managing Joe's Type 2 Diabetes (a year of routine in-network care of a wellcontrolled condition)

| The plan's overall deductible | \$0 |
|--------------------------------------|------|
| Specialist copayment | \$30 |
| Hospital (facility) <u>copayment</u> | \$0 |
| Other <u>copayment</u> | \$0 |

This EXAMPLE event includes services like: <u>Primary care physician</u> office visits (including disease education) <u>Diagnostic tests</u> (blood work) <u>Prescription drugs</u> <u>Diabetic supplies</u> (glucose meter)

| Total Example Cost | \$5,600 | | |
|---------------------------------|---------|--|--|
| In this example, Joe would pay: | | | |
| <u>Cost Sharing</u> | | | |
| <u>Deductibles</u> | \$0 | | |
| <u>Copayments</u> | \$1,000 | | |
| <u>Coinsurance</u> | \$0 | | |
| What isn't covered | | | |
| Limits or exclusions | | | |
| The total Joe would pay is | \$1,020 | | |

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

| The <u>plan's</u> overall <u>deductible</u> | \$0 |
|---|------|
| Specialist copayment | \$30 |
| Hospital (facility) <u>copayment</u> | \$0 |
| Other copayment | \$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)

| Total Example Cost | \$2,800 | |
|---------------------------------|---------|--|
| In this example, Mia would pay: | | |
| <u>Cost Sharing</u> | | |
| Deductibles | \$0 | |
| <u>Copayments</u> | \$300 | |
| <u>Coinsurance</u> | \$0 | |
| What isn't covered | | |
| Limits or exclusions | \$0 | |
| The total Mia would pay is | \$300 | |

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-982-3862.

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.

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 1-888-982-3862.

| Albanian - | Për shërbime përkthimi falas për ju, telefononi 1-888-982-3862. |
|--------------------|--|
| Amharic - | የቋንቋ አንልግሎቶችን ያለክፍያ ለማግኘት፣ በ ነ-888-982-3862 ይደውሉ። |
| Arabic - | للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء االتصال على الرقم 3862-982-1888-1 |
| Armenian - | Անվձար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-888-982-3862 հեռախոսահամարով։ |
| Bahasa Indonesia - | Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya. |
| Bantu-Kirundi - | Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-888-982-3862. |
| Bengali-Bangala - | আপনাকে বিনামূকযে ভাষা পবিকষিা পপকে হকয এই নম্বকি পেবযক ান েরুন: 1-888-982-3861 |
| Bisayan-Visayan - | Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-888-982-3862. |
| Burmese - | သင့္အေနျဖင့္ အခေၾကးေငြ မေပးရပဲ ဘာသာစကားဝန္ေဆာင္မႈမ်ား ရရွိႏုိင္ရန္ 1-888-982-3862 သို႕ ဖုန္းေခၚဆုိပါ။ |
| Catalan - | Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-888-982-3862. |
| Chamorro - | Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-888-982-3862. |
| Cherokee - | GУФЛ SODHЭФЛ OGHbGЛЛ L AГФЛ ЛGEGWЛЛ ЉУ, ФРЭЬW6Ъ 1-888-982-3862. |
| Chinese - | 如欲使用免費語言服務,請致電 1-888-982-3862. |
| Choctaw - | Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-888-982-3862. |
| Cushite - | Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-888-982-3862. |
| Dutch - | Voor gratis toegang tot taaldiensten, bell 1-888-982-3862. |
| French - | Afin d'accéder aux services langagiers sans frais, composez le 1-888-982-3862. |
| French Creole - | Pou jwenn sèvis lang gratis, rele 1-888-982-3862. |
| German - | Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-888-982-3862 an. |
| Greek - | Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-888-982-3862. |
| Gujarati - | તમારેકોઇ જાતના ખર્ચવિના ભાષાની સેિાઓની પહોોંર્ માટે, કોલ કરો1-888-982-3862. |

| Hawaiian - | No ka wala'au 'ana me ka lawelawe 'ōlelo e kahea aku i kēia helu kelepona 1-888-982-3862. Kāki 'ole 'ia kēia kōkua nei. |
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| Hindi - | आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए,1-888-982-3862 पर कॉल करें। |
| Hmong - | Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-888-982-3862. |
| lgbo - | lji nwetaòhèrè na ọrụ gasi asụsụ n'efu, kpọọ 1-888-982-3862 |
| llocano - | Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-888-982-3862. |
| Indonesian - | Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-888-982-3862. |
| Italian - | Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-888-982-3862. |
| Japanese - | 言語サービスを無料でご利用いただくには、1-888-982-3862 までお電話ください。 |
| Karen - | လၢတၢ်ကမၤန္နာ်ကို််ာအတၢ်မၬစၢၤအတၢ်ဖံးတၢ်မၤတဖဉ်လၢတအိဉ်ဒီးအၦ္ဒၤလၢကဘာ်ဟ့ဉ်အီၤအဂ်ိၢဘာ်နှဉ် ကိႏ 1-888-982-3862 တက္ၢ် |
| Korean - | 무료 언어 서비스를 이용하려면 1-888-982-3862 번으로 전화해 주십시오. |
| Kru-Bassa - | Μ dyi wuqu-dù kà kò qò ɓĕ dyi mɔú ń nì Pídyi ní, nìí, qá nɔ̀ɓà nìà kɛ: 1-888-982-3862 |
| Kurdish - | بۆ دەسپێړاگەيشتن بە خزمەتگوزارى زمان بەبى نێچوون بۆ تۆ، پەيوەندى بكە بە ژمارەي 3862-982-1888-1 |
| Laotian - | ເພື່ອເຂົ້າໃຊ້ການບໍລຶການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ1-888-982-3862 |
| Marathi - | कोणत्याही शल्ुकालशवाय भाषा सेवा प्राप्त करण्यासाठी,, 1-888-982-3862 वर फोन करा. |
| Marshallese - Micronesian- | Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-888-982-3862. |
| Pohnpeyan - | Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-888-982-3862. |
| Mon-Khmer, Cambodian - | ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-888- 982-3862។ |
| Navajo - | T'áá ni nizaad k'ehjí bee níká a'doowoł doo bą́ą́h ílínígóó kojį' hólne' 1-888-982-3862. |
| Nepali - | निःशुल्क भाषा सेवा प्राप्त गर्न 1-888-982-3862 मा टेलिफोन गर्नुहोस् । |
| Nilotic-Dinka - | Të koor yïn wɛɛ̈r de thokic ke cïn wëu kor keek tënoŋ yïn. Ke col koc ye koc kuony ne nomba 1-888-982-3862. |
| Norwegian - | For tilgang til kostnadsfri språktjenester, ring 1-888-982-3862. |
| 2 | Um Schprooch Services zu griege mitaus Koscht, ruff 1-888-982-3862. |
| Persian - | برای دسترسی به خدمات زبان به طور رایگان، با شماره 3862-982-1888 تماس بگیرید . |
| Polish - Portuguese - | Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-888-982-3862. Para acessar os serviços de idiomas sem custo para você, ligue para 1-888-982-3862. |
| i uluguese - | |

| Punjabi - | ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-888-982-3862 'ਤੇ ਫ਼ੋਨ ਕਰੋ। |
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| Romanian - | Pentru a accesa gratuit serviciile de limbă, apelați 1-888-982-3862. |
| Russian - | Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-888-982-3862. |
| Samoan - | Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-888-982-3862. |
| Serbo-Croatian - | Za besplatne prevodilačke usluge pozovite 1-888-982-3862. |
| Spanish - | Para acceder a los servicios de idiomas sin costo, llame al 1-888-982-3862. |
| Sudanic-Fulfude - | Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-888-982-3862. |
| Swahili - | Kupata huduma za lugha bila malipo kwako, piga 1-888-982-3862. |
| Syriac - | :مت بعد معدية مناهم. جل سلخونه المنابع المنابع المنابع المنابع من معدية من معدية من من معامية المن من |
| Tagalog - | Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-888-982-3862. |
| Telugu - | మీరు భాష సేవలను ఉచితంగా అందుకునందుకు, 1-888-982-3862 కు కాల్ చేయండి. |
| Thai - | หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-888-982-3862. |
| Tongan - | Kapau 'oku ke fiema'u ta'etōtōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-888-982-3862. |
| Trukese - | Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-888-982-3862. |
| Turkish - | Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-888-982-3862 numarayı arayın. |
| Ukrainian - | Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-888-982-3862. |
| Urdu - | بالقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 3862-982-1888 پر بات کریں۔ |
| Vietnamese - | Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-888-982-3862 |
| Yiddish - | 1-888-982-3862 צו צוטריט שפרַאך בַאדינונגען אין קיין פרייַז צו איר, רופן |
| Yoruba - | Lati wọnú awọn isẹ èdè l'ọfẹ fun ọ, pe 1-888-982-3862. |
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