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 or by calling 1-888-982-3862. 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 1-888-982-3862 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>In-Network: Individual $150 / Family $300. Out-of-Network: Individual $2,000 / Family $4,000.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Emergency care &amp; prescription drugs; plus in-network office visits &amp; preventive care are covered before you meet your deductible.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a></td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>In-Network: Individual $6,850 / Family $13,700. Out-Of-Network: Individual $6,000 / Family $12,000.</td>
<td>The out–of–pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out–of–pocket limits until the overall family out–of–pocket limit has been met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges, health care this plan doesn’t cover &amp; penalties for failure to obtain pre-authorization for services.</td>
<td>Even though you pay these expenses, they don’t count toward the out–of–pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-888-982-3862 for a list of in-network providers.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>$25 copay/visit, deductible doesn't apply</td>
<td>30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$40 copay/visit, deductible doesn't apply</td>
<td>30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>30% coinsurance, except routine physicals &amp; immunizations not covered</td>
<td>You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge for laboratory; $20 copay/visit for x-ray, deductible doesn't apply</td>
<td>30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$100 copay/visit, deductible doesn't apply</td>
<td>30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic drugs</td>
<td>Copay/prescription, deductible doesn't apply: $10 (retail), $20 (mail order)</td>
<td>30% coinsurance after copay/prescription, deductible doesn't apply: $10 (retail)</td>
<td>Covers 31 day supply (retail), 32-90 day supply (mail order). Includes contraceptive drugs &amp; devices obtainable from a pharmacy, oral &amp; injectable fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-network. Review your formulary for prescriptions requiring step therapy for coverage. Your cost will be higher for choosing Alternate drugs over Preferred drugs; cost difference penalty doesn't apply to out-of-pocket limit.</td>
</tr>
<tr>
<td></td>
<td>Alternate drugs</td>
<td>Copay/prescription, deductible doesn't apply: $45 (retail), $90 (mail order)</td>
<td>30% coinsurance after copay/prescription, deductible doesn't apply: $45 (retail)</td>
<td></td>
</tr>
</tbody>
</table>

More information about **prescription drug coverage** is available at [www.aetnapharmac](http://www.aetnapharmac).
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>y.com/advancedcontrol</td>
<td>Non-preferred brand drugs</td>
<td>40% copay with minimum &amp; maximum/prescription, deductible doesn't apply: $60 minimum &amp; $120 maximum (retail), $120 minimum &amp; $240 maximum (mail order)</td>
<td>Maintenance drugs- no refill restrictions or penalties apply. Members save with lower copays at CVS Caremark® Mail Service Pharmacy or CVS Pharmacy.</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Copay/prescription, deductible doesn't apply: 40%</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$300 copay/visit, deductible doesn't apply</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$150 copay/visit, deductible doesn't apply</td>
<td>Out-of-network emergency use paid the same as in-network. No coverage for non-emergency use.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$50 copay/visit, deductible doesn't apply</td>
<td>Out-of-network emergency use paid the same as in-network. 30% coinsurance for non-emergency transport out-of-network.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$400 copay/stay, deductible doesn't apply</td>
<td>Penalty of $500 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>0% coinsurance</td>
<td>None</td>
</tr>
</tbody>
</table>

If you have outpatient surgery:
- Facility fee (e.g., ambulatory surgery center): $300 copay/visit, deductible doesn't apply
- Physician/surgeon fees: No charge

If you need immediate medical attention:
- Emergency room care: $150 copay/visit, deductible doesn't apply
- Emergency medical transportation: No charge
- Urgent care: $50 copay/visit, deductible doesn't apply

If you have a hospital stay:
- Facility fee (e.g., hospital room): $400 copay/stay, deductible doesn't apply
- Physician/surgeon fees: 0% coinsurance
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay In-Network Provider (You will pay the least)</th>
<th>What You Will Pay Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office &amp; other outpatient services: $25 copay/visit, deductible doesn't apply</td>
<td>Office &amp; other outpatient services: 30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>$400 copay/stay, deductible doesn't apply</td>
<td>30% coinsurance</td>
<td>Penalty of $500 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td>Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound.) Penalty of $500 for failure to obtain pre-authorization for out-of-network care may apply.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>0% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$400 copay/stay, deductible doesn't apply; copay waived for newborn expenses</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>0% coinsurance</td>
<td>30% coinsurance</td>
<td>120 visits/calendar year. Penalty of $500 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$40 copay/visit, deductible doesn't apply</td>
<td>30% coinsurance</td>
<td>90 visits/calendar year for Speech Therapy.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$40 copay/visit, deductible doesn't apply</td>
<td>30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>$400 copay/stay</td>
<td>30% coinsurance</td>
<td>Penalty of $500 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>0% coinsurance</td>
<td>30% coinsurance</td>
<td>Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>0% coinsurance</td>
<td>30% coinsurance</td>
<td>Penalty of $500 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
</tbody>
</table>
### Common Medical Event Services You May Need

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Services Provided by In-Network Provider (You will pay the least)</th>
<th>Services Provided by Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>$40 <strong>copay</strong>/visit, deductible doesn't apply</td>
<td>30% <strong>coinsurance</strong></td>
<td>1 routine eye exam/12 months.</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered.</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered.</td>
</tr>
</tbody>
</table>

### Excluded Services & Other Covered Services:

#### Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Infertility treatment - Fertility treatments are administered through Progyny. Please call (866) 881-4029 to activate benefit.
- 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 - 10 visits/calendar year for disease, injury & chronic pain.
- Bariatric surgery
- Chiropractic care
- Hearing aids - $3,000 maximum/3 years.
- Private-duty nursing
- Routine eye care (Adult) - 1 routine eye exam/12 months.

### 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](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 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 1-888-982-3862. 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 appeal. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

**Does this plan provide Minimum Essential Coverage?** Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet Minimum Value Standards?** Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section
About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of in-network prenatal care and a hospital delivery)</th>
<th>Managing Joe’s Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia’s Simple Fracture (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan's overall deductible</td>
<td>$150</td>
<td>The plan's overall deductible</td>
</tr>
<tr>
<td>Specialist copayment</td>
<td>$40</td>
<td>Specialist copayment</td>
</tr>
<tr>
<td>Hospital (facility) copayment</td>
<td>$400</td>
<td>Hospital (facility) copayment</td>
</tr>
<tr>
<td>Other coinsurance</td>
<td>0%</td>
<td>Other coinsurance</td>
</tr>
</tbody>
</table>

This EXAMPLE event includes services like:

- Specialist office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (*ultrasounds and blood work*)
- Specialist visit (*anesthesia*)

**Total Example Cost** | $12,700

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$150</td>
</tr>
<tr>
<td>Copayments</td>
<td>$500</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn't covered**

- Limits or exclusions | $60

**The total Peg would pay is** | $710

This EXAMPLE event includes services like:

- Primary care physician office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs
- Durable medical equipment (*glucose meter*)

**Total Example Cost** | $5,600

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn't covered**

- Limits or exclusions | $20

**The total Joe would pay is** | $1,220

This EXAMPLE event includes services like:

- Emergency room care (*including medical supplies*)
- Diagnostic test (*x-ray*)
- Durable medical equipment (*crutches*)
- Rehabilitation services (*physical therapy*)

**Total Example Cost** | $2,800

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$400</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn't covered**

- Limits or exclusions | $0

**The total Mia would pay is** | $400

The plan would be responsible for the other costs of these EXAMPLE covered services.
Assistive Technology
Persons using assistive technology may not be able to fully access the following information. For assistance, please call 866-393-0002.

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

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

For language assistance in your language call 1-888-982-3862 at no cost.

**Albanian** - Për asistencë në gjuhën shqipe telefononi falas në 1-888-982-3862.

**Amharic** - እስታወቂያ ከአማርኛ ከ 1-888-982-3862 ለቀ የፈደፉት.

**Arabic** - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-888-982-3862.

**Armenian** - Ներկայումս գործվածագրեր պատահարների (համակարգեր) կանխելու 1-888-982-3862 չափազանց գնում.

**Bahasa Indonesia** - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya.

**Bantu-Kirundi** - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-888-982-3862 ku busa.

**Bengali-Bangala** - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-888-982-3862-তে কল করুন।

**Bisayan-Visayan** - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-982-3862 nga walay bayad.

**Burmese** - မြန်မာဘာသာ အကြောင်းအရာများအတွက် 1-888-982-3862 မှ ဖူးပါ။

**Catalan** - Per rebre assistència en (català), truqui al número gratuït 1-888-982-3862.

**Chamorro** - Para ayuda gi fino' (Chamoru), âgang 1-888-982-3862 sin gåstu.

**Cherokee** - ᎠᏍᎩᏔ ᎠᏔᏲ ᎠᏕᏛ ᎠᏔᏫ ᎠᏒᏍᏗ ᎠᏔᏫ 1-888-982-3862 ᎨᏗᎨ ᎠᏕᏛ ᎠᏔᏫ ᎡᏝᏍᎨ ᎠᏕᏛ ᎠᏔᏫ.

**Chinese** - 欲取得繁體中文語言協助，請撥打1-888-982-3862，無需付費。

**Choctaw** - (Chahta) anumpa ya apela a chi I paya hinla 1-888-982-3862.

**Cushite** - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-888-982-3862 irratti bilisaan bilbilaa.

**Dutch** - Bel voor tolk- en vertaal diensten in het Nederlands gratis naar 1-888-982-3862.

**French** - Pour une assistance linguistique en français appeler le 1-888-982-3862 sans frais.

**French Creole** - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-982-3862 gratis.

**German** - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-982-3862 an.

**Greek** - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-982-3862 χωρίς χρέωση.

**Gujarati** - ગુજરાતીમાં સહાય માટે કોઈ પણ કલની 1-888-982-3862 પર કોલ કરો.

**Hawaiian** - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-888-982-3862. Kāki ‘ole ‘ia kēia kōkua nei.
Hindi - हनिदी में भाषा सहायता के लिए, 1-888-982-3862 पर मुफ्त कॉल करें।
Hmong - Yog xav tau kev txhais lus Hmoob hu dawb tau rau 1-888-982-3862.
Ibo - Maka enyemaka asusu na Igbo kpọọ 1-888-982-3862 na akwụghị ụgwọ ọ bula
Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-982-3862 nga awan ti bayadanyo.
Italian - Per ricevere assistenza linguistica in italiano, puo' chiamare gratuitamente 1-888-982-3862.
Japanese - 日本語で援助をご希望の方は、1-888-982-3862 まで無料でお電話ください。
Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862 번으로 전화해 주십시오.
Kru-Bassa - Be'm ké gbo-kpá-kpá dyé pidyi dë Başo-wuquún væc, dà 1-888-982-3862
Kurdish - 1-888-982-3862
Laotian - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-982-3862 ni sohte isais.
Marathi - कोणत्याही शुल्कवाय भाषा सेवा प्राप्त करण्यासाठी, 1-888-982-3862 वर फोन करा.
Mon-Khmer, Cambodian - ២០០០-១-៨៨៨-៩៨២-៣៨៦២ ដោយគោលការណ៍
Navajo - T'aá shi shizaad k'ehjí bee shiká a'dowol ninízingo Diné k'ehjí kojí' t'áá jiík'e hólne' 1-888-982-3862
Nepali - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-888-982-3862 मा फोन गर्नुहोस्।
Nilotic-Dinka - Tën kucony ê thok ê Thuonjän col 1-888-982-3862 kecin ayóc.
Norwegian - For språkassistance på norsk, ring 1-888-982-3862 kostnadsfritt.
Panjabi - ਪੰਜਾਬੀ ਦੀ ਦੰਦ ਵਾਲੀ ਮਾਤਰਾ ਲੱਡੀ, 1-888-982-3862 ਦੇ ਮੁਫ਼ਤ ਵਾਲੀ ਬੜੀ।
Persian - برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 به دون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-982-3862.
Portuguese - Para obter assistência linguística em português ligue para o 1-888-982-3862 gratuitamente.
Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-888-982-3862.
Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-888-982-3862.

Samoan - Mo fesoasoani tau gagana le Gagana Samoa vala'au le 1-888-982-3862 e aunoa ma se totogi.

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-888-982-3862.

Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-888-982-3862.

Sudanic-Fulfude - Fii yo on hebul balloon e ko yowitii e haala Pular noddele oo numero doo 1-888-982-3862. Njodi woo fawaaki on.

Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-888-982-3862 bila malipo.

Syriac - ١-٨٨٨-٩٨٢-٣٨٦٢

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-982-3862 nang walang bayad.

Telugu - వాస్తవంగా ప్రత్యేక పాఠసమాఖ్యలు పరిశీలించడానికి వైఫ్యుంది కానీ 1-888-982-3862 కనుక ప్రాంచేదింది. (టెలుగు)

Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-888-982-3862 ฟรีไม่มีค่าใช้จ่าย

Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-888-982-3862 'o 'ikai hā ōtōngi.

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-888-982-3862 nge esapw kamé ngonuk.

Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödedenen 1-888-982-3862.

Ukrainian - Щоб отримати допомогу перекладача українською мови, зв'яжить за безкоштовним номером 1-888-982-3862.

Urdu - 1-888-982-3862.

Vietnamese - Đế được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-888-982-3862.

Yiddish - 1-888-982-3862

Yoruba - Fún irànìwọ nípa èdè (Yorùbá) pe 1-888-982-3862 lái san owó kankan rárá.