



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 1-888-982-3862. 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.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	Medicare Assigned Claims: \$600 Medicare Non-Assigned Claims: \$600 Medicare Non-Covered In-Network Claims: \$600 Medicare Non-Covered Out-of-Network: \$600	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. Does not apply to preventive care.
<b>Are there services covered before you meet your deductible?</b>	Yes. <u>Preventive care</u> is 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. 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>
<b>Are there other deductibles for specific services?</b>	Yes. Private Duty Nursing: \$50 Pharmacy: \$100	You must pay all of the costs for these services up to the <u>deductible</u> amount before this plan begins to pay for these services.
<b>What is the out-of-pocket limit for this plan?</b>	Medicare Claims: \$600 Medicare Non-Assigned Claims: \$600 Medicare Non-Covered Claims for Services the Plan Covers: In-Network: \$1,950; Out-of-Network: \$2,955	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.
<b>What is not included in the out-of-pocket limit?</b>	<u>Premiums</u> , <u>balance-billing</u> charges, prescription costs, 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> .
<b>Will you pay less if you use a network provider?</b>	Yes. For services not covered by Medicare, go to <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-855-221-1536 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.
<b>Do you need a referral to see a specialist?</b>	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	Out-of-Network	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	Medicare Claims: 0% co-insurance Medicare Non-Covered In-Network Claims: 10% co-insurance	Medicare Non-Covered Out-of-Network Claims: 20% co-insurance	Includes Telemedicine. Coinsurance is after deductible.
If you visit a health care <u>provider's</u> office or clinic	<u>Specialist</u> visit	Medicare Claims: 0% co-insurance Medicare Non-Covered In-Network Claims: 10% co-insurance	Medicare Non-Covered Out-of-Network Claims: 20% co-insurance	Includes Telemedicine. Coinsurance is after deductible.
If you visit a health care <u>provider's</u> office or clinic	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	Not covered	None
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Medicare Claims: 0% co-insurance Medicare Non-Covered In-Network Claims: 10% co-insurance	Medicare Non-Covered Out-of-Network Claims: 20% co-insurance	None. Coinsurance is after deductible.
If you have a test	Imaging (CT/PET scans, MRIs)	Medicare Claims: 0% co-insurance Medicare Non-Covered In-Network Claims: 10% co-insurance	Medicare Non-Covered Out-of-Network Claims: 20% co-insurance	None. Coinsurance is after deductible.
If you need drugs to treat your illness or condition  More information about <u>prescription drug coverage</u> is available at <a href="http://www.medimpact.com">www.medimpact.com</a>	Generic drugs	30% co-insurance with a minimum \$5 <u>copay</u> /script	Not covered	Pharmacy <u>deductible</u> applies. Certain drugs require step therapy, quantity limits, and/or prior authorization. Some drugs are excluded from coverage.
	Preferred brand drugs	30% co-insurance with a minimum \$5 <u>copay</u> /script	Not covered	
	Non-preferred brand drugs	50% <u>coinsurance</u> / script both in or out of the coverage gap	Not covered	
	<u>Specialty drugs</u>	30% co-insurance with a minimum \$5 <u>copay</u> /script	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network	Out-of-Network	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Medicare Claims: 0% co-insurance Medicare Non-Covered In-Network Claims: 10% co-insurance	Medicare Non-Covered Out-of-Network Claims: 20% co-insurance	None. Coinsurance is after deductible.
<b>If you have outpatient surgery</b>	Physician/surgeon fees	Medicare Claims: 0% co-insurance Medicare Non-Covered In-Network Claims: 10% co-insurance	Medicare Non-Covered Out-of-Network Claims: 20% co-insurance	None. Coinsurance is after deductible.
<b>If you need immediate medical attention If you need immediate medical attention</b>	<u>Emergency Room Care</u>	Medicare Claims: 0% co-insurance; Medicare Non-Covered In-Network Claims: \$75 <u>copay</u> and 10% co-insurance		Copay is waived if patient is admitted or accidental injury. Non-emergent use of an out-of-network emergent care <u>provider</u> : 20% <u>coinsurance</u> . Coinsurance is after deductible.
	<u>Emergency medical transportation</u>	Medicare Claims: 0% co-insurance Medicare Non-Covered In-Network Claims: 10% co-insurance	Medicare Non-Covered Out-of-Network Claims: 10% co-insurance	Services are excluded if they do not meet emergency criteria. Coinsurance is after deductible.
	<u>Urgent care</u>	Medicare Claims: 0% co-insurance Medicare Non-Covered In-Network Claims: 10% co-insurance	Medicare Non-Covered Out-of-Network Claims: 10% co-insurance	20% <u>coinsurance</u> for out-of-network non-urgent use. Coinsurance is after deductible.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Medicare Claims: 0% co-insurance Medicare Non-Covered In-Network Claims: 10% co-insurance	Medicare Non-Covered Out-of-Network Claims: 20% co-insurance	Coinsurance is after deductible.
<b>If you have a hospital stay</b>	Physician/surgeon fees	Medicare Claims: 0% co-insurance Medicare Non-Covered In-Network Claims: 10% co-insurance	Medicare Non-Covered Out-of-Network Claims: 20% co-insurance	Coinsurance is after deductible.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network	Out-of-Network	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Medicare Claims: 0% co-insurance Medicare Non-Covered In-Network Claims: 10% co-insurance	Medicare Non-Covered Out-of- Network Claims: 20% co-insurance	Coinsurance is after deductible.
If you need mental health, behavioral health, or substance abuse services	Inpatient services	Medicare Claims: 0% co-insurance Medicare Non-Covered In-Network Claims: 10% co-insurance	Medicare Non-Covered Out-of- Network Claims: 20% co-insurance	Coinsurance is after deductible.
If you are pregnant	Office visits	Prenatal care: No charge; Postnatal care/Inpatient services: In-network Medicare Claims: 0% co-insurance OON Medicare Non-Covered Claims: 10% co-insurance	Medicare Non-Covered Out-of- Network Claims: 20% co-insurance	Coinsurance is after deductible.
If you are pregnant	Childbirth/delivery professional services	Postnatal care/Inpatient services: Medicare Claims: 0% co-insurance Medicare Non-Covered Claims: 10% co-insurance	Medicare Non-Covered Out-of- Network Claims: 20% co-insurance	Coinsurance is after deductible.
If you are pregnant	Childbirth/delivery facility services	Postnatal care/Inpatient services: Medicare Claims: 0% co-insurance Medicare Non-Covered Claims: 10% co-insurance	Medicare Non-Covered Out-of- Network Claims: 20% co-insurance	Coinsurance is after deductible.
If you need help recovering or have other special health needs	<u>Home health care</u>	Medicare Claims: 0% co-insurance Medicare Non-Covered In-Network Claims: 10% co-insurance	Medicare Non-Covered Out-of- Network Claims: 20% co-insurance	Coinsurance is after deductible.
If you need help recovering or have other special health needs	<u>Rehabilitation services</u>	Medicare Claims: 0% co-insurance Medicare Non-Covered In-Network Claims: 10% co-insurance	Medicare Non-Covered Out-of- Network Claims: 20% co-insurance	Non-covered claims limited to 60 visits/calendar year for Physical, Occupational & Speech Therapy combined. Coinsurance is after deductible.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network	Out-of-Network	
If you need help recovering or have other special health needs	<u>Habilitation services</u>	Medicare Claims: 0% co-insurance Medicare Non-Covered In-Network Claims: 10% co-insurance	Medicare Non-Covered Out-of- Network Claims: 20% co-insurance	Coinurance is after deductible.
If you need help recovering or have other special health needs	<u>Skilled nursing care</u>	Medicare Claims: 0% co-insurance Medicare Non-Covered In-Network Claims: 10% co-insurance	Medicare Non-Covered Out-of- Network Claims: 20% co-insurance	Coinurance is after deductible.
If you need help recovering or have other special health needs	<u>Durable medical equipment</u>	Medicare Claims: 0% co-insurance Medicare Non-Covered In-Network Claims: 10% co-insurance	Medicare Non-Covered Out-of- Network Claims: 20% co-insurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse. Coinurance is after deductible.
If you need help recovering or have other special health needs	<u>Hospice services</u>	Medicare Claims: 0% co-insurance Medicare Non-Covered In-Network Claims: 10% co-insurance	Medicare Non-Covered Out-of- Network Claims: 20% co-insurance	Coinurance is after deductible.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered.
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:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult & Child)
- Routine foot care
- Weight loss programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Chiropractic care
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- 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 1-855-221-1536.
- 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 [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](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, 1-855-221-1536.
- 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 [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).
- 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 Standard? 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 <u>plan's</u> overall <u>deductible</u>	\$600
■ <u>Specialist</u> <u>coinsurance</u>	0%
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	0%

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

<b>Total Example Cost</b>	<b>\$12,800</b>
<b>In this example, Peg would pay:</b>	
<i>Cost Sharing</i>	
Deductibles	\$600
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$150
<b>The total Peg would pay is</b>	<b>\$750</b>

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

■ The <u>plan's</u> overall <u>deductible</u>	\$600
■ <u>Specialist</u> <u>coinsurance</u>	0%
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	0%

**This EXAMPLE event includes services like:**  
Primary care physician office visits (*including disease education*)  
Diagnostic tests (*blood work*)  
Prescription drugs  
Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$7,400</b>
<b>In this example, Joe would pay:</b>	
<i>Cost Sharing</i>	
Deductibles	\$600
Copayments/Coinsurance	\$0
Prescription Costs	\$1200
<i>What isn't covered</i>	
Limits or exclusions	\$80
<b>The total Joe would pay is</b>	<b>\$1880</b>

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

■ The <u>plan's</u> overall <u>deductible</u>	\$600
■ <u>Specialist</u> <u>coinsurance</u>	0%
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	0%

**This EXAMPLE event includes services like:**  
Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>	
Deductibles	\$600
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$600</b>

### 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 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).**

**Language Assistance:**

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-888-982-3862.
Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-888-982-3862 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-888-982-3862
Armenian -	Lեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-888-982-3862 առանց գնով:
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 numero 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 -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-888-982-3862 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-888-982-3862.
Chamorro -	Para ayuda gi fino' (Chamoru), ágang 1-888-982-3862 sin gãstu.
Cherokee -	Θαύση Ψάλλοθαυ ΛησοςΠωθυ ΘεΤ (GWY) @BWó's 1-888-982-3862 O'T L AΓωΛ JEGPJ hPRθ.
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 l 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 vertaaldiensten 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 ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-888-982-3862 પર કૉલ 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 -	हन्दि में भाषा सहायता के लएि, 1-888-982-3862 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-982-3862.
Ibo -	Maka enyemaka asụsụ na Igbo kpọọ 1-888-982-3862 na akwụghị ụgwọ ọ bụla
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, può 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。
Karen -	လၢတၢ်မၤစၢၤတၢ်ကတိၤကိၣ်အံၤနီၣ် ကိၣ် နီၣ်: 1-888-982-3862 လၢတၢ်အိၣ်ဒီးတၢ်လၢၢ်ဘျၣ်လၢၢ်စ့ၤဘျၣ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862번으로 전화해 주십시오.
Kru-Bassa -	Ḃe m'ké gbo-kpá-kpá dyé pídyi dé Ḃaśóó-wuḍuũn wěě, dǎ 1-888-982-3862
Kurdish -	برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 به خۆرای یه یۆمندی بکەن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-888-982-3862 ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi -	तीलभाषा (मराठी) सहाय्यासाठी 1-888-982-3862 क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-888-982-3862 ilo ejjelok wōnān.
Micronesian-Pohnpeyan -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-982-3862 ni sohte isais.
Mon-Khmer, Cambodian -	សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទទេលកាន់លេខ 1-888-982-3862 ដោយឥតគិតថ្លៃ។
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-888-982-3862
Nepali -	(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1- 888-982-3862 मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tèn kuɔɔny ë thok ë Thuɔŋjäŋ col 1-888-982-3862 kec'in ayöc.
Norwegian -	For språkassistanse på norsk, ring 1-888-982-3862 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-982-3862 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Hefle in Deitsch, ruf: 1-888-982-3862 aa. Es Aaruf koschtet nix.
Persian -	برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 بدون 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.
Samoaan -	Mo fesoasoani tau gagana I 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 hebu balal e ko yowitii e haala Pular noddee e 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 -	ܠܚܥܠܐ ܕܥܝܢܐ ܕܡܕܢܬܐ ܕܡܕܢܬܐ ܕܡܕܢܬܐ ܕܡܕܢܬܐ ܕܡܕܢܬܐ 1-888-982-3862 ܕܡܕܢܬܐ.
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-982-3862 nang walang bayad.
Telugu -	భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-888-982-3862 కు కాల్ చేయండి. (తెలుగు)
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 ʻōtōngi.
Trukese -	Ren ánninnisin chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-888-982-3862 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemedен 1-888-982-3862.
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-982-3862.
Urdu -	اگر آپ کو کسی اور زبان کی مدد کی ضرورت ہے تو 1-888-982-3862 پر بلا کسی خرچ کی ضرورت کے بغیر کال کریں۔
Vietnamese -	Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-888-982-3862.
Yiddish -	פאר שפראך הילף אין אידיש רופט 1-888-982-3862 פאר א פאפאל.
Yoruba -	Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-888-982-3862 láí san owó kankan rárá.