



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, [www.HealthReformPlanSBC.com](http://www.HealthReformPlanSBC.com) or by calling 1-800-370-4526. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-800-370-4526 to request a copy.

| Important Questions                                                 | Answers                                                                                                                                       | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <u>deductible</u> ?                             | In- <u>Network</u> : Individual \$500 / Family \$1,000.<br>Out-of- <u>Network</u> : Individual \$500 / Family \$1,000.                        | 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; 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>                                              |
| Are there other <u>deductibles</u> for specific services?           | No.                                                                                                                                           | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?       | In- <u>Network</u> : Individual \$2,000 / Family \$4,000.<br>Out-of- <u>Network</u> : Individual \$4,000 / Family \$8,000.                    | 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 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>Premiums</u> , balance-billing charges & health care this <u>plan</u> doesn't cover.                                                       | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Will you pay less if you use a <u>network provider</u> ?            | Yes. See <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-800-370-4526 for a list of in- <u>network providers</u> . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u> ?          | No.                                                                                                                                           | You can see the <u>specialist</u> you choose without a <u>referral</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event                                          | Services You May Need                                   | What You Will Pay                                                                       |                                                                                         | Limitations, Exceptions, & Other Important Information                                                                                                                  |
|---------------------------------------------------------------|---------------------------------------------------------|-----------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                               |                                                         | In-Network Provider<br>(You will pay the least)                                         | Out-of-Network Provider<br>(You will pay the most)                                      |                                                                                                                                                                         |
| If you visit a health care <u>provider's</u> office or clinic | Primary care visit                                      | \$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply                               | 40% <u>coinsurance</u> after deductible                                                 | None                                                                                                                                                                    |
|                                                               | <u>Specialist</u> visit                                 | \$40 <u>copay</u> /visit, <u>deductible</u> doesn't apply                               | 40% <u>coinsurance</u> after deductible                                                 | None                                                                                                                                                                    |
|                                                               | <u>Preventive care</u> / <u>screening</u> /immunization | No charge                                                                               | 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                                            | <u>Diagnostic test</u> (x-ray, blood work)              | 20% <u>coinsurance</u>                                                                  | 40% <u>coinsurance</u>                                                                  | None                                                                                                                                                                    |
|                                                               | Imaging (CT/PET scans, MRIs)                            | 20% <u>coinsurance</u>                                                                  | 40% <u>coinsurance</u>                                                                  | None                                                                                                                                                                    |
| If you need drugs to treat your illness or condition          | Generic drugs                                           | Retail & mail 20% coinsurance until MOOP has been satisfied                             |                                                                                         | RX Coverage through Express – Scripts                                                                                                                                   |
|                                                               | Preferred brand drugs                                   |                                                                                         |                                                                                         | Mail Order up to 90 day's supply 20%                                                                                                                                    |
|                                                               | Non-preferred brand drugs                               |                                                                                         |                                                                                         | Mandatory Accredo – Express-Scripts Specialty Pharmacy                                                                                                                  |
|                                                               | <u>Specialty drugs</u>                                  |                                                                                         |                                                                                         |                                                                                                                                                                         |
| If you have outpatient surgery                                | Facility fee (e.g., ambulatory surgery center)          | 20% <u>coinsurance</u>                                                                  | 40% <u>coinsurance</u>                                                                  | None                                                                                                                                                                    |
|                                                               | Physician/surgeon fees                                  | 20% <u>coinsurance</u>                                                                  | 40% <u>coinsurance</u>                                                                  | None                                                                                                                                                                    |
| If you need immediate medical attention                       | <u>Emergency room care</u>                              | 20% <u>coinsurance</u> after \$100 <u>copay</u> /visit, <u>deductible</u> doesn't apply | 20% <u>coinsurance</u> after \$100 <u>copay</u> /visit, <u>deductible</u> doesn't apply | No coverage for non-emergency use.                                                                                                                                      |
|                                                               | <u>Emergency medical transportation</u>                 | 20% <u>coinsurance</u> after deductible                                                 | 20% <u>coinsurance</u> after deductible                                                 | Non-emergency transport: not covered, except 40% <u>coinsurance</u> if pre-authorized.                                                                                  |

| Common Medical Event                                                      | Services You May Need                     | What You Will Pay                                                                             |                                                            | Limitations, Exceptions, & Other Important Information                                                                                                                                                                          |
|---------------------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------------------------------------------|------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                           | In-Network Provider<br>(You will pay the least)                                               | Out-of-Network Provider<br>(You will pay the most)         |                                                                                                                                                                                                                                 |
|                                                                           | <u>Urgent care</u>                        | \$40 <u>copay</u> /visit, <u>deductible</u> doesn't apply                                     | 40% <u>coinsurance</u>                                     | None                                                                                                                                                                                                                            |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)        | 20% <u>coinsurance</u>                                                                        | 40% <u>coinsurance</u>                                     | <u>Pre-authorization</u> required for out-of-network care.                                                                                                                                                                      |
|                                                                           | Physician/surgeon fees                    | 20% <u>coinsurance</u>                                                                        | 40% <u>coinsurance</u>                                     | None                                                                                                                                                                                                                            |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | Office & other outpatient services: \$40 <u>copay</u> /visit, <u>deductible</u> doesn't apply | Office & other outpatient services: 40% <u>coinsurance</u> | None                                                                                                                                                                                                                            |
|                                                                           | Inpatient services                        | 20% <u>coinsurance</u>                                                                        | 40% <u>coinsurance</u>                                     | <u>Pre-authorization</u> required for out-of-network care.                                                                                                                                                                      |
| If you are pregnant                                                       | Office visits                             | No charge                                                                                     | 40% <u>coinsurance</u>                                     | <u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) <u>Pre-authorization</u> for out-of-network care may apply. |
|                                                                           | Childbirth/delivery professional services | 20% <u>coinsurance</u>                                                                        | 40% <u>coinsurance</u>                                     |                                                                                                                                                                                                                                 |
|                                                                           | Childbirth/delivery facility services     | 20% <u>coinsurance</u>                                                                        | 40% <u>coinsurance</u>                                     |                                                                                                                                                                                                                                 |
| If you need help recovering or have other special health needs            | <u>Home health care</u>                   | 20% <u>coinsurance</u>                                                                        | 40% <u>coinsurance</u>                                     | 120 visits/calendar year, including up to 70- 8 hour shifts for private-duty nursing. <u>Pre-authorization</u> required for out-of-network care.                                                                                |
|                                                                           | <u>Rehabilitation services</u>            | \$40 <u>copay</u> /visit, <u>deductible</u> doesn't apply                                     | 40% <u>coinsurance</u>                                     | 30 visits/condition for Physical, Occupational & Speech Therapy combined, including outpatient hospital/facility services.                                                                                                      |
|                                                                           | <u>Habilitation services</u>              | \$40 <u>copay</u> /visit, <u>deductible</u> doesn't apply                                     | 40% <u>coinsurance</u>                                     | None                                                                                                                                                                                                                            |
|                                                                           | <u>Skilled nursing care</u>               | 20% <u>coinsurance</u>                                                                        | 40% <u>coinsurance</u>                                     | 240 days/calendar year. <u>Pre-authorization</u> required for out-of-network care.                                                                                                                                              |
|                                                                           | <u>Durable medical equipment</u>          | 20% <u>coinsurance</u>                                                                        | 40% <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 Will Pay                               |                                                    | Limitations, Exceptions, & Other Important Information     |
|----------------------------------------|----------------------------|-------------------------------------------------|----------------------------------------------------|------------------------------------------------------------|
|                                        |                            | In-Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                            |
|                                        | Hospice services           | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | <u>Pre-authorization</u> required for out-of-network care. |
| If your child needs dental or eye care | Children's eye exam        | No charge                                       | Not covered                                        | 1 routine eye exam/24 months.                              |
|                                        | Children's glasses         | Not covered                                     | Not covered                                        | Not covered.                                               |
|                                        | Children's dental check-up | Not covered                                     | Not covered                                        | Not covered.                                               |

### Excluded Services & Other Covered Services:

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

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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
- Bariatric surgery
- Chiropractic care - 30 visits/calendar year combined in and out of network.
- Hearing aids - 1 hearing aid to \$1,000 maximum per ear/24 months up to age 16.
- Infertility treatment - For more information & exceptions, see policy document provided by your employer.
- Private-duty nursing - 70- 8 hour shifts/calendar year combined with home health care.
- Routine eye care (Adult) - 1 routine eye exam/24 months for in-network only.

### Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For more information on your rights to continue coverage, contact the plan at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <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 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:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <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.**

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? No.**

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> | \$500 |
| ■ <u>Specialist</u> <u>copayment</u>          | \$40  |
| ■ Hospital (facility) <u>coinsurance</u>      | 20%   |
| ■ Other <u>coinsurance</u>                    | 20%   |

**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>\$12,700</b> |
| <b>In this example, Peg would pay:</b> |                 |
| <u>Cost Sharing</u>                    |                 |
| <u>Deductibles</u>                     | \$500           |
| <u>Copayments</u>                      | \$0             |
| <u>Coinsurance</u>                     | \$1,500         |
| <u>What isn't covered</u>              |                 |
| Limits or exclusions                   | \$70            |
| <b>The total Peg would pay is</b>      | <b>\$2,070</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> | \$500 |
| ■ <u>Specialist</u> <u>copayment</u>          | \$40  |
| ■ Hospital (facility) <u>coinsurance</u>      | 20%   |
| ■ Other <u>coinsurance</u>                    | 20%   |

**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>\$5,600</b> |
| <b>In this example, Joe would pay:</b> |                |
| <u>Cost Sharing</u>                    |                |
| <u>Deductibles</u>                     | \$100          |
| <u>Copayments</u>                      | \$200          |
| <u>Coinsurance</u>                     | \$0            |
| <u>What isn't covered</u>              |                |
| Limits or exclusions                   | \$4,300        |
| <b>The total Joe would pay is</b>      | <b>\$4,600</b> |

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

|                                               |       |
|-----------------------------------------------|-------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$500 |
| ■ <u>Specialist</u> <u>copayment</u>          | \$40  |
| ■ Hospital (facility) <u>coinsurance</u>      | 20%   |
| ■ Other <u>coinsurance</u>                    | 20%   |

**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>\$2,800</b> |
| <b>In this example, Mia would pay:</b> |                |
| <u>Cost Sharing</u>                    |                |
| <u>Deductibles</u>                     | \$500          |
| <u>Copayments</u>                      | \$200          |
| <u>Coinsurance</u>                     | \$300          |
| <u>What isn't covered</u>              |                |
| Limits or exclusions                   | \$10           |
| <b>The total Mia would pay is</b>      | <b>\$1,010</b> |

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-370-4526.

### 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, or disability.

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](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.**

**Language Assistance:**

|                    |                                                                                                                          |
|--------------------|--------------------------------------------------------------------------------------------------------------------------|
| 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 numero 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 -          | ငွေတုန့်ကျခံစရာမလိုဘဲ (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 -         | ᏅᎠᏂᏍᏆ ᏳᏗᏞᏪᏫᏚᏱ ᏤᏃᏐᏩᏴᏫᏚ ᏅᏔᏲ (GWY) ᏓᏊᏄᏨᏩᏳ 1-800-370-4526 ᏕᏀᏲ Ꮯ ᏲᏬᏐᏱ ᏢᑦᑖᑖᏱ ᏂᏳᏲᏀ.                                             |
| 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 lakkokkofsaa 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 કોલ 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 -                | हन्दिी 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 akwughị ugwo ọ bụla                                   |
| Ilocano -              | Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-370-4526 nga awan ti bayadanyo.                |
| Italian -              | Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-370-4526.              |
| Japanese -             | 日本語で援助をご希望の方は、1-800-370-4526 まで無料でお電話ください。                                                               |
| Karen -                | လၢတၢ်မၤစၢၤတၢ်ကတိၤကိၣ်အီၣ် ၁-800-370-4526 လၢတၢ်အိၣ်ဒီးတၢ်လၢၢ်သ့ၣ်လၢၢ်စ့ၤ                                  |
| Korean -               | 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-370-4526 번으로 전화해 주십시오.                                                |
| Kru-Bassa -            | Be'm'ké gbo-kpá-kpá dyé pidyi dé Baśwó'-wuḍuñ wěě, dá 1-800-370-4526                                     |
| Kurdish -              | برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 به خۆرای یه یۆمندی بکهن.                             |
| Laotian -              | ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-800-370-4526 ໂດຍບໍ່ເສຍຄ່າໂທ.                     |
| Marathi -              | कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-800-370-4526 वर फोन करा.                           |
| Marshallese -          | Nān 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 निःशुल्क भाषा सहायता पाउनका लागि 1-800-370-4526 मा फोन गर्नुहोस् ।                           |
| Nilotic-Dinka -        | Tën kuwoɲy è thok ë Thuonjäŋ cöl 1-800-370-4526 kec'in ayöc.                                             |
| Norwegian -            | For språkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt.                                         |
| Panjabi -              | ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਮਦਦ ਲਈ, 1-800-370-4526 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।                                              |
| Pennsylvania Dutch -   | Fer Hilfe in Deutsch, ruf: 1-800-370-4526 aa. Es Aaruf koschtet nix.                                     |
| Persian -              | برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 بدون هیچ هزینه ای تماس بگیرید. انگلیسی               |
| Polish -               | Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-370-4526.                         |
| Portuguese -           | Para obter assistência linguística em português ligue para o 1-800-370-4526 gratuitamente.               |
| Romanian -             | Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-800-370-4526                   |

[illegible]