### Summary of Benefits and Coverage

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, visit [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](https://www.healthcare.gov/sbc) or call 1-888-982-3862 to request a copy.

### Important Questions | Answers | Why This Matters:
--- | --- | ---
**What is the overall deductible?** | Home Hospital: Individual $1,200 / Family $2,400. Aetna: Individual $1,200 / Family $2,400. Out-of-Network: Individual $2,400 / Family $4,800. | 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.

**Are there services covered before you meet your deductible?** | Yes. In-network preventive care; plus home hospital inpatient hospital services are covered before you meet your deductible. | 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 [https://www.healthcare.gov/coverage/preventive-care-benefits/](https://www.healthcare.gov/coverage/preventive-care-benefits/)

**Are there other deductibles for specific services?** | Yes, on retail Prescription Drugs: $100 deductible per person/$200 family for preferred and non-preferred brand drugs | You must satisfy this prescription drug deductible for preferred and non-preferred drugs before coinsurance applies. Mail Order Prescriptions - deductible does not apply. What you pay toward your plan’s deductible, coinsurance and copays are all applied to your out-of-pocket max.

**What is the out-of-pocket limit for this plan?** | Home Hospital: Individual $4,000 / Family $8,000. Aetna: Individual 4,000 / Family 8,000. Out-of-Network: Individual $8,000 / Family $16,000. | 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.

**What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges, health care this plan doesn’t cover & penalties for failure to obtain pre-authorization for services. | Even though you pay these expenses, they don’t count toward the out-of-pocket limit.

**Will you pay less if you use a network provider?** | Yes. See [www.aetna.com/docfind](http://www.aetna.com/docfind) or call 1-800-231-7729 for a list of home hospital providers. | You pay the least if you use a provider in Home Hospital Provider Network. You pay more if you use a provider in Aetna Provider 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.
<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<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>Home Hospital Provider (You will pay the least)</th>
<th>Aetna Provider (You will pay more)</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>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>No charge</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>Retail: you pay 15% to a maximum of $200 per script Mail Order: you pay 5% to a maximum of $400 per script</td>
<td>Retail: you pay 15% to a maximum of $200 per script Mail Order: you pay 5% to a maximum of $400 per script</td>
<td>Not covered</td>
<td>Not covered through Aetna medical plan, covered through CVS/Caremark. In Network: $100 Deductible Per Person/$200 Family. Mail Order - Deductible does not apply.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>Retail: you pay 30% to a maximum of $200 per script Mail Order: you pay 15% to a maximum of $400 per script</td>
<td>Retail: you pay 30% to a maximum of $200 per script Mail Order: you pay 15% to a maximum of $400 per script</td>
<td>Not covered</td>
<td>Certain women’s preventive services will be covered with no cost to the member. For a full list of these prescriptions and/or services, please contact CVS/Caremark. Retail: 1 copay per 30 day supply RX Out-of-Pocket Expense Limit: $3,000 Person/$6,000 Family</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Home Hospital Provider (You will pay the least)</td>
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<td>Limitations, Exceptions, &amp; Other Important Information</td>
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</tbody>
</table>
|                      | Non-preferred brand drugs | Retail: you pay 45% to a maximum of $400 per script  
Mail Order: you pay 25% to a maximum of $400 per script | Retail: you pay 45% to a maximum of $400 per script  
Mail Order: you pay 25% to a maximum of $400 per script | Not covered | Prior authorization and step therapy may apply. |
|                      | Specialty drugs | Retail: you pay 45% to a maximum of $400 per script  
Mail Order: you pay 25% to a maximum of $400 per script | Retail: you pay 45% to a maximum of $400 per script  
Mail Order: you pay 25% to a maximum of $400 per script | Not covered | Prior Authorization and step therapy may apply |
<p>| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 20% coinsurance | 50% coinsurance | None |
|                      | Physician/surgeon fees | 10% coinsurance | 20% coinsurance | 50% coinsurance | None |
| If you need immediate medical attention | Emergency room care | $150 copay; deductible waived if admitted. | $150 copay; deductible waived if admitted. | 20% coinsurance | No coverage for non-emergency use. |
|                      | Emergency medical transportation | 20% coinsurance | 20% coinsurance | 20% coinsurance | Non-emergency transport: not covered, except if pre-authorized. |
|                      | Urgent care | 10% coinsurance | 20% coinsurance | 50% coinsurance | No coverage for non-urgent use. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 10% coinsurance after $100 copay/stay, deductible doesn't apply | 20% coinsurance after $250 copay/stay | 50% coinsurance after $500 copay/stay | Penalty of $400 for failure to obtain pre-authorization for out-of-network care. |</p>
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Home Hospital Provider (You will pay the least)</th>
<th>Aetna Provider (You will pay more)</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>If you need mental health, behavioral health, or substance abuse services</td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance, deductible doesn't apply</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Outpatient services</td>
<td>Office &amp; other outpatient services: 10% coinsurance</td>
<td>Office &amp; other outpatient services: 20% coinsurance</td>
<td>Office &amp; other outpatient services: 50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>10% coinsurance after $100 copay/stay, deductible doesn't apply</td>
<td>20% coinsurance after $250 copay/stay</td>
<td>50% coinsurance after $500 copay/stay</td>
<td>Penalty of $400 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>No charge</td>
<td>50% coinsurance</td>
<td>Cost sharing doesn't apply to certain preventive services. Maternity care may include tests &amp; services described elsewhere in the SBC (i.e. ultrasound). Penalty of $400 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>10% coinsurance, deductible doesn't apply</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>10% coinsurance after $100 copay/stay, deductible doesn't apply</td>
<td>20% coinsurance after $250 copay/stay</td>
<td>50% coinsurance after $500 copay/stay</td>
<td>None</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>3 visits/day. Penalty of $400 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>10% coinsurance after $100 copay/stay, deductible doesn't apply</td>
<td>20% coinsurance after $250 copay/stay</td>
<td>50% coinsurance after $500 copay/stay</td>
<td>Penalty of $400 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Home Hospital Provider (You will pay the least)</td>
<td>Aetna Provider (You will pay more)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
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<td>-----------------------</td>
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<td>-----------------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>10% coinsurance after $100 copay/stay for inpatient, deductible doesn’t apply; 10% coinsurance for outpatient</td>
<td>20% coinsurance after $250 copay/stay for inpatient; 20% coinsurance for outpatient</td>
<td>50% coinsurance after $500 copay/stay for inpatient; 50% coinsurance for outpatient</td>
<td>Penalty of $400 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
</tbody>
</table>

**If your child needs dental or eye care**

<table>
<thead>
<tr>
<th>Services</th>
<th>Home Hospital Provider</th>
<th>Aetna Provider</th>
<th>Out-of-Network Provider</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children's eye exam</td>
<td>No charge</td>
<td>No charge</td>
<td>50% coinsurance</td>
<td>1 routine eye exam/12 months.</td>
</tr>
<tr>
<td>Children's glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Children's dental check-up</td>
<td>Not covered</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)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Prescription Drugs
- 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 - 30 visits/calendar year.
- Bariatric surgery
- Chiropractic care
- Private-duty nursing - 45-8 hour shifts/calendar year.
- 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 https://www.dol.gov/agencies/ebsa.
• For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
• If your coverage is a church 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 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 1-888-982-3862.
• 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 https://www.dol.gov/agencies/ebsa.
• 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.
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 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.

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#### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible: $1,200
- Specialist coinsurance: 10%
- Hospital (facility) coinsurance: 10%
- Other coinsurance: 10%

**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: $12,800**

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,200</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,100</td>
</tr>
</tbody>
</table>

**What isn't covered**
- Limits or exclusions: $100

**The total Peg would pay is $2,400**

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

- The plan's overall deductible: $1,200
- Specialist coinsurance: 10%
- Hospital (facility) coinsurance: 10%
- Other coinsurance: 10%

**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: $7,400**

In this example, Joe would pay:

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

**What isn't covered**
- Limits or exclusions: $0

**The total Joe would pay is $7,200**

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

- The plan's overall deductible: $1,200
- Specialist coinsurance: 10%
- Hospital (facility) coinsurance: 10%
- Other coinsurance: 10%

**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: $1,900**

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,200</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$90</td>
</tr>
</tbody>
</table>

**What isn't covered**
- Limits or exclusions: $0

**The total Mia would pay is $1,290**

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**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: 1-888-982-3862.
**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.

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).
TTY: 711

Language Assistance:

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

Albanian - Për asistencë në gjühën shqipe telefononi falas në 1-888-982-3862.
Amharic - እንዳቹ እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እን እنزللغة

Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-888-982-3862.
Armenian - թելադիի գնովով թագովով իրականության (հայերեն) քացի 1-888-982-3862 վարձակալ 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 nomero 1-888-982-3862 ku busa
Bengali-Bangala - বাংলাদেশ 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 - မြန်မာစိုက်မြန်မာစိုက် သို့မဟုတ်(မြန်မာစိုက်မြန်မာစိုက်) 1-888-982-3862 အတွက် ကျင်းပါသည်။
Catalan - Per rebre assistència en (català), truqui al número gratuït 1-888-982-3862.
Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-888-982-3862 sin gâstu.
Cherokee - ᓁᏱᏪᏰ ᎠᏱᏱ, ᎠᏱᏱ, ᎠᏱᏱ, ᎠᏱᏱ, ᎠᏱᏱ, ᎠᏱᏱ, ᎠᏱᏱ, ᎠᏱᏱ, ᎠᏱᏱ, ᎠᏱᏱ, ᎠᏱᏱ, ᎠᏱᏱ, ᎠᏱᏱ, ᎠᏱ�, ᎠᏱ�, ᎠᏱ�, ᎠᏱ�, ᎠᏱ�, ᎠᏱ�, ᎠᏱ�, ᎠᏱ�, ᎠᏱ�, ᎠᏱ�, ᎠᏱ�, ᎠᏱ�, Ꭰ�є立案

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 hiikuur argachuuf lakkokkofsa bilbilaa 1-888-982-3862 irratti bilisaan bilbilaa.
Dutch - Bel voor toll- 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 સહાય માટે કોઈપણ સસ્તન વર્ણ 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.
1-888-982-3862

Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-982-3862.

Maka enyemaka asusuy na Igbo kpọọ 1-888-982-3862 na akwughị ụgwọ ọ byla

Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-982-3862 nga awan ti bayadanyo.

Per ricevhere assistenza linguistica in italiano, puo chiamare gratuitamente 1-888-982-3862.

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。

한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862 번으로 전화해 주십시오.

cción de los operatives para el servicio de asistencia lingüística de manera gratuita para el español, dirigen a 1-888-982-3862.

For språkassistance på norsk, ring 1-888-982-3862 kostnadsfritt.

Ươm palen sawas en sou kawewe ni omw lokaia Ponape koahl 1-800-682-9020 ni sohte isais.

1-888-982-3862

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1-888-982-3862

Fer Helfe in Deitsch, ruf: 1-888-982-3862 aa. Es Aaruf koschhtet nix.

Aby uzyskać pomoc w języku polskim, zadzwoni bezpłatnie pod numer 1-888-982-3862.

Para obter assistência linguística em português ligue para o 1-888-982-3862 gratuitamente.

 Pentru asistență lingvistică în româneste telefonați la numărul gratuit 1-888-982-3862

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-888-982-3862.
<table>
<thead>
<tr>
<th>Language</th>
<th>Translation</th>
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<tbody>
<tr>
<td>Samoan</td>
<td>Mo fesoasoani tau gagana I le Gagana Samoa vala’au le 1-888-982-3862 e aunoa ma se totogi.</td>
</tr>
<tr>
<td>Serbo-Croatian</td>
<td>Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-888-982-3862.</td>
</tr>
<tr>
<td>Spanish</td>
<td>Para obtener asistencia lingüística en español, llame sin cargo al 1-888-982-3862.</td>
</tr>
<tr>
<td>Sudanic-Fulfude</td>
<td>Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-888-982-3862. Njodi woo fawaaki on.</td>
</tr>
<tr>
<td>Swahili</td>
<td>Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-888-982-3862 bila malipo.</td>
</tr>
<tr>
<td>Syriac</td>
<td>Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-982-3862 nang walang bayad.</td>
</tr>
<tr>
<td>Tagalog</td>
<td>Kapau ‘oku fiema’u hā tokoni ‘i he lea faka-Tonga telefoni 1-888-982-3862 ‘o ‘ikai hā ōtōngi.</td>
</tr>
<tr>
<td>Telugu</td>
<td>Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-888-982-3862 nge esapw kamé ngonuk.</td>
</tr>
<tr>
<td>Thai</td>
<td>สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-888-982-3862 ฟรีไม่มีค่าใช้จ่าย</td>
</tr>
<tr>
<td>Tongan</td>
<td>Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-888-982-3862 nge esapw kamé ngonuk.</td>
</tr>
<tr>
<td>Trukese</td>
<td>(Dil) çağrısı dil yardım için. Hiçbir ücret ödededen 1-888-982-3862.</td>
</tr>
<tr>
<td>Ukrainian</td>
<td>Щоб отримати допомогу перекладача української мови, залиште телефонний номер 1-888-982-3862.</td>
</tr>
<tr>
<td>Urdu</td>
<td>ء ارک ل کسٹم رپ 1-888-982-3862 8 سل کسٹم او مین للو رپ و دیر</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>Đệ được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-888-982-3862.</td>
</tr>
<tr>
<td>Yiddish</td>
<td>פארא שפראר הייטך אונא יידיש רופט פארא קות סחלצלא. 1-888-982-3862</td>
</tr>
<tr>
<td>Yoruba</td>
<td>Fún ̀ràǹlọ̀wọ̀ nípa èdè (Yorùbá) pe 1-888-982-3862 lái san owó kankan rárá.</td>
</tr>
</tbody>
</table>