



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, www.HealthReformPlanSBC.com or by calling 1-800-370-4526. 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 deductible?	In- <u>Network</u> : Individual \$1,700 / Family \$3,400 Out-of- <u>Network</u> : Individual \$3,000 / Family \$6,000.	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. Once the family deductible limit is met, all family members will be considered to have met the deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care 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. 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 https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You must pay all of the costs for non-preventative services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for non-preventative services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	In- <u>Network</u> : Individual \$3,000 / Family \$6,000. Out-of- <u>Network</u> : Individual \$6,000 / Family \$12,000.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. Once the family out of pocket maximum is met, all family members will be considered to have met the out of pocket maximum.
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 & penalties for failure to obtain <u>pre-authorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.aetna.com/docfind 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 charge</u> 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30 <u>copay</u> /visit after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	None
	<u>Specialist</u> visit	\$50 <u>copay</u> /visit after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	None
	<u>Preventive care/screening/immunization</u>	No charge	40% <u>coinsurance</u> after <u>deductible</u>	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> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.aetnapharmacy.com/standardoptout	Generic drugs	20% <u>coinsurance</u> after <u>deductible</u> (retail), 15% <u>coinsurance</u> after <u>deductible</u> (mail order)	20% <u>coinsurance</u> after <u>deductible</u> (retail), 15% <u>coinsurance</u> after <u>deductible</u> (mail order)	Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in- <u>network</u> . Review your <u>formulary</u> for prescriptions requiring precertification or step therapy for coverage.
	Preferred brand drugs	25% <u>coinsurance</u> after <u>deductible</u> (retail), 20% <u>coinsurance</u> after <u>deductible</u> (mail order)	25% <u>coinsurance</u> after <u>deductible</u> (retail), 20% <u>coinsurance</u> after <u>deductible</u> (mail order)	
	Non-preferred brand drugs	37.5% <u>coinsurance</u> after <u>deductible</u> (retail), 30% <u>coinsurance</u> after <u>deductible</u> (mail order)	37.5% <u>coinsurance</u> (retail), 30% <u>coinsurance</u> (mail order)	
	<u>Specialty drugs</u>	Applicable cost as noted above <u>after deductible</u> for generic or brand drugs	Not covered	First prescription fill at a retail pharmacy or specialty pharmacy. Subsequent fills must be through the Aetna Specialty Pharmacy <u>Network</u> .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance after deductible</u>	40% <u>coinsurance after deductible</u>	No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	20% <u>coinsurance after deductible</u>	40% <u>coinsurance after deductible</u>	Non-emergency transport: not covered, except 40% <u>coinsurance</u> if pre-authorized.
	<u>Urgent care</u>	20% <u>coinsurance after deductible</u>	40% <u>coinsurance after deductible</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance after deductible</u>	40% <u>coinsurance after deductible</u>	Penalty of \$400 (or 50% of <u>allowed amount</u>) for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Physician/surgeon fees	20% <u>coinsurance after deductible</u>	40% <u>coinsurance after deductible</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance after deductible</u>	40% <u>coinsurance after deductible</u>	None
	Inpatient services	20% <u>coinsurance after deductible</u>	40% <u>coinsurance after deductible</u>	Penalty of \$400 (or 50% of <u>allowed amount</u>) for failure to obtain <u>pre-authorization</u> for out-of-network care.
If you are pregnant	Office visits	\$50 <u>copay/visit after deductible</u>	40% <u>coinsurance after deductible</u>	
	Childbirth/delivery professional services	20% <u>coinsurance after deductible</u>	40% <u>coinsurance after deductible</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.) Penalty of \$400 (or 50% of <u>allowed amount</u>) for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
	Childbirth/delivery facility services	20% <u>coinsurance after deductible</u>	40% <u>coinsurance after deductible</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance after deductible</u>	40% <u>coinsurance after deductible</u>	Penalty of \$400 (or 50% of <u>allowed amount</u>) for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Rehabilitation services</u>	\$50 <u>copay/visit after deductible</u>	40% <u>coinsurance after deductible</u>	60 visits/calendar year for Physical & Occupational Therapy combined.
	<u>Habilitation services</u>	\$50 <u>copay/visit after deductible</u>	40% <u>coinsurance after deductible</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Skilled nursing care</u>	20% <u>coinsurance after deductible</u>	40% <u>coinsurance after deductible</u>	Penalty of \$400 (or 50% of <u>allowed amount</u>) for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Durable medical equipment</u>	20% <u>coinsurance after deductible</u>	40% <u>coinsurance after deductible</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	20% <u>coinsurance after deductible</u>	40% <u>coinsurance after deductible</u>	Penalty of \$400 (or 50% of <u>allowed amount</u>) for failure to obtain <u>pre-authorization</u> for out-of-network care.
If your child needs dental or eye care	Children's eye exam	\$30 <u>copay/visit after deductible</u>	Not covered	1 routine eye exam/12 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 <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult & Child) 	<ul style="list-style-type: none"> • Glasses (Child) • Hearing aids • Long-term care 	<ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • Routine foot care • Weight loss programs - Except for required <u>preventive services</u>.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> • Acupuncture (at specialist copayment) • Bariatric surgery • Chiropractic care 	<ul style="list-style-type: none"> • Infertility treatment - For more information & exceptions, see policy document provided by your employer. 	<ul style="list-style-type: none"> • Private-duty nursing - 70- 8 hour shifts/calendar year. • Routine eye care (Adult) - 1 routine eye exam/12 months for <u>in-network</u> only.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends.

- 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.
- Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: [insert applicable contact information from instructions].

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 the 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.

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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 plan's overall deductible \$1,700
- Specialist copayment \$50
- Hospital (facility) coinsurance 20%
- Diagnostic test coinsurance 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*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,700
<u>Copayments</u>	\$50
<u>Coinsurance</u>	\$1,250
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,060

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$1,700
- Primary care copayment \$30
- Diagnostic test coinsurance 20%
- DME coinsurance 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*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,700
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$800
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,720

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$1,700
- Specialist copayment \$50
- Hospital (facility) coinsurance 20%
- Habilitation copayment \$50

This EXAMPLE event includes services like:

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

Total Example Cost	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,700
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$80
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,180

The plan would be responsible for the other costs of these EXAMPLE covered services.

TTY: 711

Language Assistance:

For language assistance in your language call 1-800-370-4526 at no cost.

- 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 ամանց զևով:
- 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 - ငွေတန်ကျခံရမလိုဘဲ (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 - ᎠᎩᎠᎵ ᎠᎵᎠᎵᎠ ᎠᎵᎠᎵᎠ ᎠᎵᎠᎵᎠ ᎠᎵᎠᎵᎠ (GWY) ᎠᎵᎠᎵᎠᎵᎠ 1-800-370-4526 ᎠᎵᎠᎵ ᎠᎵᎠᎵᎠ ᎠᎵᎠᎵᎠ ᎠᎵᎠᎵᎠ.
- 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 lakkokkofsa 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 - လာဝတ်မစာလာဝတ်ကတိလ်ဂျိအဂီၢ် ကျိၣ် ၁-800-370-4526 လာဝတ်အိၣ်ဒီးလာဝတ်လူၣ်လာဝတ်စုၣ်
- 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 Bāsóó`wuḍuūñ wɛɛ, dá 1-800-370-4526**
- Kurdish - **برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 به خۆرای یه یومندی بکمن.**
- Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-800-370-4526 ໂດຍບໍ່ເສຍຄ່າໂທ.
- Marathi - कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-800-370-4526 वर फोन करा.
- Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-370-4526 ilo ejjelok wōnān.
- Micronesian - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-370-4526 ni sohte isais.
- Pohnpeyan - **សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-800-370-4526 ដោយឥតគិតថ្លៃ។**
- Mon-Khmer, Cambodian - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-800-370-4526
- Navajo - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-800-370-4526 मा फोन गर्नुहोस् ।
- Nepali - Tën kuwoɲy ë thok ë Thuonjǎŋ cɔl 1-800-370-4526 kecin ayöc.
- Nilotic-Dinka - For språkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt.
- Norwegian - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-370-4526 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।
- Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-370-4526 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।

- Pennsylvania Dutch - Fer Hefje in Deitsch, 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
- Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-370-4526.
- Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-800-370-4526 e aunoa ma se totogi.
- Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatno broj 1-800-370-4526.
- Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-800-370-4526.
- Sudanic-Fulfude - Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-800-370-4526. Njodi woo fawaaki on.
- Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-370-4526 bila malipo.
- Syriac - ܟܠ ܟܨܟܐ ܟܠ ܗܢܗܘܐ ܕܗܘܐ ܟܠ ܗܢܗܘܐ ܟܠ ܗܢܗܘܐ ܟܠ ܗܢܗܘܐ ܟܠ ܗܢܗܘܐ ܟܠ ܗܢܗܘܐ ܟܠ ܗܢܗܘܐ 1-800-370-4526 ܗܢܗܘܐ.
- Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-370-4526 nang walang bayad.
- Telugu - భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-800-370-4526 కు కాల్ చేయండి. (తెలుగు)
- Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-800-370-4526 ฟรีไม่มีค่าใช้จ่าย
- Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-800-370-4526 'o 'ikai hā ʻotōngi.
- Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-800-370-4526 nge esapw kamé ngonuk.
- Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemedir 1-800-370-4526.
- Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-370-4526.
- Urdu - بلا قیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-800-370-4526 پر بات کریں۔
- Vietnamese - Đê đươc hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-800-370-4526.
- Yiddish - פאר שפראך הילף אין אידיש רופט 1-800-370-4526 פאר"י פון אפצאל.
- Yoruba - Fún ìrànlọ́wọ̀ nípa èdè (Yorùbá) pe 1-800-370-4526 láí san owó kankan rárá.