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 https://www.aetna.com/sbcsearch/getpolicydocs?u=080700-110020-012268 or call 1-888-982-3862. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-888-982-3862 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>In-Network: EE Only $1,750; EE+ Family $3,000. Out-of-Network: EE Only $3,000; EE+ Family $6,000.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. In-network preventive care is covered before you meet your deductible.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>In-Network: EE Only $3,000; EE+ Family $6,000. Out-of-Network: EE Only $6,000; EE+ Family $12,000.</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges, health care this plan doesn’t cover &amp; penalties for failure to obtain pre-authorization for services.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.aetna.com/docfind">http://www.aetna.com/docfind</a> or call 1-888-982-3862 for a list of in-network providers.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<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>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>30% coinsurance, except no charge for well child &amp; child immunizations</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Preferred generic drugs</td>
<td><strong>Copay/prescription:</strong> $10 (retail), $25 (mail order)</td>
<td>30% coinsurance after copay/prescription: $10 (retail)</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td><strong>Copay/prescription:</strong> $25 (retail), $62.50 (mail order)</td>
<td>30% coinsurance after copay/prescription: $25 (retail)</td>
</tr>
<tr>
<td></td>
<td>Non-preferred generic/brand drugs</td>
<td><strong>Copay/prescription:</strong> $50 (retail), $125 (mail order)</td>
<td>30% coinsurance after copay/prescription: $50 (retail)</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Applicable cost as noted above for generic or brand drugs</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>--------------------------------</td>
<td>---------------------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office &amp; other outpatient services: 20% coinsurance</td>
<td>Office &amp; other outpatient services: 30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>15% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------</td>
<td>-----------------------</td>
<td>----------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>In-Network Provider (You will pay the least)</strong></td>
<td><strong>Out-of-Network Provider (You will pay the most)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td><strong>Home health care</strong></td>
<td>20% coinsurance</td>
<td>25% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Limitations</strong></td>
<td>40 visits/calendar year. Penalty of $400 (or 50% of allowed amount if less) for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Exceptions</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Rehabilitation services</strong></td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Limitations</strong></td>
<td>60 visits/calendar year for Physical, Occupational &amp; Speech Therapy combined.</td>
</tr>
<tr>
<td></td>
<td><strong>Habilitation services</strong></td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Limitations</strong></td>
<td>None</td>
</tr>
<tr>
<td></td>
<td><strong>Skilled nursing care</strong></td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Limitations</strong></td>
<td>60 days/calendar year. Penalty of $400 (or 50% of allowed amount if less) for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td><strong>Durable medical equipment</strong></td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Limitations</strong></td>
<td>Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.</td>
</tr>
<tr>
<td></td>
<td><strong>Hospice services</strong></td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Limitations</strong></td>
<td>Penalty of $400 (or 50% of allowed amount if less) for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td><strong>Children’s eye exam</strong></td>
<td>No charge</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Limitations</strong></td>
<td>1 routine eye exam/24 months.</td>
</tr>
<tr>
<td></td>
<td><strong>Children's glasses</strong></td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Limitations</strong></td>
<td>Not covered.</td>
</tr>
<tr>
<td></td>
<td><strong>Children’s dental check-up</strong></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)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs - Except for required preventive services.
- Infertility treatment - For more information & exceptions, see policy document using summary box link on page 1 or call the number on your ID card.
- Routine eye care (Adult) - 1 routine eye exam/24 months.

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

- Acupuncture - 10 visits/calendar year for disease, injury & chronic pain.
- Bariatric surgery
- Chiropractic care
- Hearing aids - 1 hearing aid per ear/3 years.

**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:
Department of Financial Services, Consumer Assistance Unit, 800-342-3736, https://www.dfs.ny.gov/consumers/health_insurance/home.

- If your group health coverage is subject to ERISA, you may also contact the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For more information on your rights to continue coverage, contact the plan at 1-888-982-3862.
- 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 on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general toll free number at 1-888-982-3862. You may also contact the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- Department of Financial Services, Consumer Assistance Unit, 800-342-3736, https://www.dfs.ny.gov/consumers/health_insurance/home.
- 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 Community Health Advocates, Community Service Society of New York, 633 Third Avenue 10th Floor, New York, NY 10017, 1-888-614-5400, http://www.communityhealthadvocates.org/

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

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

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

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

---

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The plan’s overall deductible: $1,750
- Specialist coinsurance: 20%
- Hospital (facility) coinsurance: 20%
- Other 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

**In this example, Peg would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,750</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,300</td>
</tr>
</tbody>
</table>

**What isn’t covered**: $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: $1,750
- Specialist coinsurance: 20%
- Hospital (facility) coinsurance: 20%
- Other 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

**In this example, Joe would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,750</td>
</tr>
<tr>
<td>Copayments</td>
<td>$600</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$100</td>
</tr>
</tbody>
</table>

**What isn’t covered**: $20

**The total Joe would pay is**: $2,470

---

### Mia’s Simple Fracture

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

- The plan’s overall deductible: $1,750
- Specialist coinsurance: 20%
- Hospital (facility) coinsurance: 20%
- Other coinsurance: 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)

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

**In this example, Mia would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,750</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$200</td>
</tr>
</tbody>
</table>

**What isn’t covered**: $0

**The total Mia would pay is**: $1,950

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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.

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

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Published: 11/08/2022
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 unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, disability, gender identity or sexual orientation.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies, including Aetna Life Insurance Company and its affiliates (Aetna).
TTY: 711

Language Assistance:

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

Albanian - Për asistencë në gjëhën shqipe telefononi falas në 1-888-982-3862.
Amharic - ኢየደር ከማ ከ ከሚማማ ከ 1-888-982-3862 ሕላ ይመለስ.
Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-888-982-3862.
Armenian - Լեզվի գործիչության այցելումը (հայերեն) կատարեք 1-888-982-3862 անցած գնիլ:
Bahasa-Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya.
Bantu-Kirundi - Nib a urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-888-982-3862 ku busa
Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বলিন্মূল্য 1-888-982-3862-এ কল করুন।
Bisayan-Visayan - Alang sa pag-abag sa pinulongang sa (Binisayang Sinugboanon) tawag sa 1-888-982-3862 nga walay bayad.
Burmese - 1-888-982-3862
Catalan - Per rebrer assistència en (català), truqui al número gratuït 1-888-982-3862.
Chamorro - Para ayuda gi fino' (Chamoru), ágang 1-888-982-3862 sin gástu.
Cherokee - ᎠᏂ渔民 ᏭᏯᏗ ᏠᏂᏍᏗᏗᏗ (GWW) ᏨᏗᏬᏗᏗ 1-888-982-3862 ᎨᏗᏬ ଏᏗᏗATED. hFR.Θ.
Chinese - 欲取得繁體中文語言協助，請撥打 1-888-982-3862，無需付費。
Choctaw - (Chahta) anumpa ya apela a chi I paya hinla 1-888-982-3862.
Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-888-982-3862 irratti bilisaan bilbilaa.
Dutch - Bel voor tolk- en 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 સાહિત્ય માટે કોઈ પણ પરસ્પરબેંગ 1-888-982-3862 પર કોલ કરો.
No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-888-982-3862. Kāki ‘ole ‘ia kēia kōkua nei.

Hindi - हिन्दी में भाषा सहायता के लिए, 1-888-982-3862 पर मुफ्त कॉल करें।

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

Ibo - Maka enyemaka asụsụ na Igbo kpọọ 1-888-982-3862 na akwụgbị ụgwọ ọ bụla

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

Italian - Per ricevere assistenza linguistica in italiano, puó chiamare gratuitamente 1-888-982-3862.

Japanese - 日本語で援助をご希望の方は、1-888-982-3862 まで無料でお電話ください。

Karen - 代表性のある文章を書くために、1-888-982-3862 を電話します。

Kurdish - 1-888-982-3862

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

Kru-Bassa - Ɓɛ́ m̀ ké gbo-kpá-kpá dyi pidyi dë Başɔ̀-wudjuùn weè, dà 1-888-982-3862

Kurdish - برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 به خورای پامورهدی بکان.

Laotian - ທ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ແກຣາທິດທາຍ 1-888-982-3862 ທ່ານທ່ານໄດ້ຮູບ.

Marathi - कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-888-982-3862 वर फोन करा.

Marshallese - Ñan bôk jipañ ilo Kajin Majol, kallok 1-888-982-3862 ilo ejjelok wônân.

Micronesian - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-982-3862 ni sohte isais.

Mon-Khmer, Cambodian - សូមសិក្សាប្រសើរប្រសើរសម្រាប់អត្តសញ្ញាណ 1-888-982-3862 ប្រសើរប្រសើរសម្រាប់អត្តសញ្ញាណ។

Navajo - Táá shi shizaad k'ehji bee shiká a’doo wol ninizingo Diné k’ehji koji’ t’áá jílk’è hólne’ 1-888-982-3862

Nepali - (नेपाली) मा निश्चित भाषा सहायता पाउनका लागाँ 1-888-982-3862 मा फोन गर्नुहोस्।

Nilotic-Dinka - Tên kuocny è thok è Thuonjânc col 1-888-982-3862 keći ayòcc.

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

Punjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-982-3862 ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।

Persian - برای راهنمایی به زبان فارسی با شماره 1-888-982-3862.

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

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

Romanian - Pentru asistență lingvistică în română, teferiți la numărul gratuit 1-888-982-3862.

Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-888-982-3862.

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

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

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

Sudanic-Fulfude - Fii yo on hebu balal e ko yowitzi e haala Pular noddee e oo numero doo 1-888-982-3862 Njodi woo fawaaki on.

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

Syriac - ܢܶܐ ܐܶܥܳܒ ܢܰܐ ̱ܬ ܐܬܽܘܢܬܕܰܥܡ ܐܳܢܫܶܠܳܒ ܐܳܿܝܳܝܪܽܘܳܣ ܐܳܗ ܟܳܠ ܐܳܡܩܰܪ ܢܘܣܳܠܰܬܕ 1-888-982-3862 ܢܳܓܰܡܘ.

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

Telugu - భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-888-982-3862 కు కాల్ చేయండి.

Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็นภาษาไทย โทร 1-888-982-3862 ฟรีไม่มีค่าใช้จ่าย.

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

Trukese - Ren aninisin chiak re (Kapasen Chuuk) kopwe këkëkëri 1-888-982-3862 nge esapw kamé ngonuk.

Turkish - (Dil) çağrı dil yardım için. Hiçbir ücret ödedemen 1-888-982-3862.

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-982-3862.

Urdu - بلیقیہ زبان سے متعلق خدمات حاصل کرنے کے لئے 1-888-982-3862.

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

Yiddish - זאָר шפראַר הילעג און אידישָה רעט 1-888-982-3862.

Yoruba - Fún irlọ́nọ́wọ́ nipa èdè (Yorùbá) pe 1-888-982-3862 lái san owó kankan rará.