



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 1-844-373-2094. 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 1-844-373-2094 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In- <u>Network</u> : Individual \$500 / Family \$1,000. 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 deductible?	Yes. Emergency care; In- <u>network</u> & out-of- <u>network</u> <u>prescription drugs</u> ; plus Tier 1 in- <u>network</u> & in- <u>network</u> office visits & <u>preventive care</u> are covered before you meet your deductible.	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 don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	In- <u>Network</u> : Individual \$2,200 / Family \$4,400. Out-of- <u>Network</u> : Individual \$2,200 / Family \$4,400.	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 out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> 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 network provider?	Yes. See www.aetna.com/docfind or call 1-844-373-2094 for a list of Tier 1 In- <u>Network</u> .	You pay the least if you use a <u>provider</u> in Tier 1 In- <u>Network</u> . You pay more if you use a <u>provider</u> in In- <u>Network</u> <u>Provider</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 referral to see a specialist?	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
		Tier 1 In-Network (You will pay the least)	In-Network Provider (You will pay more)	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	\$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$25 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$40 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	None
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	No charge	30% <u>coinsurance</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)	10% <u>coinsurance</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Imaging</u> (CT/PET scans, MRIs)	Not applicable	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.aetnapharmacy.com/standard	Preferred generic drugs (Includes Tier 1A - Value Drugs and Tier 1 Preferred Generic Prescription Drugs)	Not applicable	<u>Copay/prescription</u> : Tier 1A 10% <u>coinsurance</u> up to maximum/ <u>prescription</u> , <u>deductible</u> doesn't apply: \$10 (retail), \$20 (mail order); Preferred Generic 20% <u>coinsurance</u> up to maximum/ <u>prescription</u> , <u>deductible</u> doesn't apply: \$20 (retail), \$40 (mail order)	<u>Copay/prescription</u> : Tier 1A 10% <u>coinsurance</u> up to maximum/ <u>prescription</u> , <u>deductible</u> doesn't apply: \$10 (retail); Preferred Generic 20% <u>coinsurance</u> up to maximum/ <u>prescription</u> , <u>deductible</u> doesn't apply: \$20 (retail)	Covers 90 day supply (retail & mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for preferred generic FDA-approved women's contraceptives <u>in-network</u> .

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 In-Network (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	Preferred brand drugs	Not applicable	30% <u>coinsurance</u> up to maximum/prescription, <u>deductible</u> doesn't apply: \$50 (retail), \$100 (mail order)	30% <u>coinsurance</u> up to maximum/prescription, <u>deductible</u> doesn't apply: \$50 (retail)	
	Non-preferred generic/brand drugs	Not applicable	50% <u>coinsurance</u> up to maximum/prescription, <u>deductible</u> doesn't apply: \$100 (retail), \$200 (mail order)	50% <u>coinsurance</u> up to maximum/prescription, <u>deductible</u> doesn't apply: \$100 (retail)	
	<u>Specialty drugs</u>	Not applicable	Applicable cost as noted above for generic or brand drugs	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not applicable	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Physician/surgeon fees	Not applicable	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$300 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$300 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$300 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	\$250 <u>copay</u> /trip, <u>deductible</u> doesn't apply	\$250 <u>copay</u> /trip, <u>deductible</u> doesn't apply	\$250 <u>copay</u> /trip, <u>deductible</u> doesn't apply	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	Not applicable	\$40 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$40 <u>copay</u> /visit, <u>deductible</u> doesn't apply	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	Not applicable	20% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Pre-authorization</u> required for out-of-network care.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 In-Network (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	Not applicable	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$10 <u>copay/visit</u> , <u>deductible</u> doesn't apply; other outpatient services: 20% <u>coinsurance</u>	Office: \$25 <u>copay/visit</u> , <u>deductible</u> doesn't apply; other outpatient services: 20% <u>coinsurance</u>	Office & other outpatient services: 30% <u>coinsurance</u>	None
	Inpatient services	Not applicable	20% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Pre-authorization</u> required for out-of-network care.
If you are pregnant	Office visits	No charge after \$20 <u>copay for initial visit to confirm pregnancy</u> ; <u>deductible</u> doesn't apply	No charge after \$40 <u>copay for initial visit to confirm pregnancy</u> ; <u>deductible</u> doesn't apply	30% <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	Not applicable	20% <u>coinsurance</u>	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	Not applicable	20% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	Not applicable	20% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Pre-authorization</u> required for out-of-network care.
	<u>Rehabilitation services</u>	Not applicable	\$40 <u>copay/visit</u> , <u>deductible</u> doesn't	30% <u>coinsurance</u>	60 visits/calendar year for Physical, Occupational & Speech Therapy combined, including outpatient hospital services.
	<u>Habilitation services</u>	Not applicable	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Skilled nursing care</u>	Not applicable	20% <u>coinsurance</u>	30% <u>coinsurance</u>	150 days/calendar year. <u>Pre-authorization</u> required for out-of-network care.
	<u>Durable medical equipment</u>	Not applicable	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	Not applicable	0% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Pre-authorization</u> required for out-of-network care.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 In-Network (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not applicable	No charge	No charge	1 routine eye exam/calendar year.
	Children's glasses	Not covered	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	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 - 20 visits/calendar year for disease, injury & chronic pain.
- Bariatric surgery
- Chiropractic care - 40 visits/calendar year.
- Private-duty nursing
- Hearing aids - 80% after deductible, 2 hearing aids per 36 months to age 19. And 80% after deductible, 2 hearing aids and max of \$3,000 per 36 months from age 19 and above.
- Routine eye care (Adult) - 1 routine eye exam/calendar year.
- Infertility treatment - \$10,000 lifetime limit per covered person. For more information & exceptions, see policy document provided by your employer or call the number on your ID card.

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 1-844-373-2094.
- 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.
- 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 number at 1-844-373-2094. 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.
- 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? 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 \$500
- Specialist copayment \$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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$20
<u>Coinsurance</u>	\$1,700
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,280

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

- The plan's overall deductible \$500
- Specialist copayment \$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
- Diabetic supplies (*glucose meter*)

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

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$1,100
<u>Coinsurance</u>	\$10
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,630

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

- The plan's overall deductible \$500
- Specialist copayment \$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
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In this example, Mia would pay:

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

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-844-373-2094.

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:

To access language services at no cost to you, call 1-844-373-2094.

- Albanian - Për shërbime përkthimi falas për ju, telefononi 1-844-373-2094.
- Amharic - የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-844-373-2094 ይደውሉ።
- Arabic - للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-844-373-2094
- Armenian - Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-844-373-2094 հեռախոսահամարով:
- Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-844-373-2094 tanpa dikenakan biaya.
- Bantu-Kirundi - Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-844-373-2094.
- Bengali-Bangala - আপনাকে বিনামূল্যে ভাষা পবিকষিা পপকে হকয এই নম্বকি পেবযক ান েরুন: 1-888-982-386।
- Bisayan-Visayan - Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-844-373-2094.
- Burmese - သင့်အေ့ဖုင့် အခေဖုကးေငြိ မေပးရဲပဲ ဘာသာစကားဝန့်ေဆာငွးမ်း ရရှိို့ိုင့်န့် 1-844-373-2094 သို့ၼ ဖုန့်းေခင့်ဆို့ိုပါ။
- Catalan - Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-844-373-2094.
- Chamorro - Para un hago' i setbision lengguãhi ni dibåtde para hãgu, ågang 1-844-373-2094.
- Cherokee - Ⴀႃ႗ႃ Ⴀႃ႗ႃ႗ႃ Ⴀႃ႗ႃ႗ႃ Ⴀႃ႗ႃ Ⴀႃ႗ႃ Ⴀႃ႗ႃ႗ႃ Ⴀႃ႗ႃ႗ႃ 1-844-373-2094.
- Chinese - 如欲使用免費語言服務，請致電 1-844-373-2094.
- Choctaw - Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-844-373-2094.
- Cushite - Tajaajiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-844-373-2094.
- Dutch - Voor gratis toegang tot taaldiensten, bell 1-844-373-2094.
- French - Afin d'accéder aux services langagiers sans frais, composez le 1-844-373-2094.
- French Creole - Pou jwenn sèvis lang gratis, rele 1-844-373-2094.
- German - Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-844-373-2094 an.
- Greek - Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-844-373-2094.
- Gujarati - તમારેકોઇ જાતના ખર્ચવિના ભાષાની સેિાઓની પહોોર માટે, કોલ કરો1-844-373-2094.

- Hawaiian - No ka wala'au 'ana me ka lawelawe 'ōlelo e kahea aku i kēia helu kelepona 1-844-373-2094. Kāki 'ole 'ia kēia kōkua nei.
- Hindi - आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए, 1-844-373-2094 पर कॉल करें।
- Hmong - Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-844-373-2094.
- Igbo - Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ 1-844-373-2094
- Ilocano - Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-844-373-2094.
- Indonesian - Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-844-373-2094.
- Italian - Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-844-373-2094.
- Japanese - 言語サービスを無料でご利用いただくには、1-844-373-2094 までお電話ください。
- Karen - လာတာကမနာကိာ်အတာမစာအတာဖံးတာမတဖ်လာတအိာ်ဒီးအပူလာကဘာ်ဟ့ာ်အိအဂီာ်ဘာ်န့ာ် ကိး 1-844-373-2094 တက့ာ်.
- Korean - 무료 언어 서비스를 이용하려면 1-844-373-2094 번으로 전화해 주십시오.
- Kru-Bassa - M̈ dyi wuɖu-dù kà kò dò bě dyi mɔú n̈ nì Pídyi ní, níí, d̈á nòbà nià ke: 1-844-373-2094
- Kurdish - بو دەسپێرێ گەشتن بە خزمەتگوزاری زمان بەی تێچوون بو تو، پەیمندی بکە بە ژمارە 1-844-373-2094
- Laotian - ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໃດໜຶ່ງຢ່າຈ່າຄ່າບໍລິການ, ໃຫ້ໂທຫາເບີ1-888-982-3862
- Marathi - कोणत्याही शब्दकालशाखा भाषा सेवा प्राप्त करण्यासाठी,, 1-844-373-2094 वर फोन करा.
- Marshallese - Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-844-373-2094.
- Micronesian-Pohnpeyan - Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-844-373-2094.
- Mon-Khmer, Cambodian - ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-888-982-3862។
- Navajo - T'áá ni nizaad k'ehjí bee níká a'doowoł doo báááh ílínígóó kojí' hólne' 1-844-373-2094.
- Nepali - निःशुल्क भाषा सेवा प्राप्त गर्न 1-844-373-2094 मा टेलिफोन गर्नुहोस् ।
- Nilotic-Dinka - Të koor yin wëëř de thokic ke cïn wëu kør keek tənɔŋ yin. Ke cɔl kɔc ye kɔc kuony ne nɔmba 1-844-373-2094.
- Norwegian - For tilgang til kostnadsfri språktjenester, ring 1-844-373-2094.
- Pennsylvania Dutch - Um Schprooch Services zu griege mitaus Koscht, ruff 1-844-373-2094.
- Persian - برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-844-373-2094 تماس بگیرید .
- Polish - Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-844-373-2094.
- Portuguese - Para acessar os serviços de idiomas sem custo para você, ligue para 1-844-373-2094.
- Punjabi - ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-844-373-2094 'ਤੇ ਫ਼ੋਨ ਕਰੋ।

