



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, [www.HealthReformPlanSBC.com](http://www.HealthReformPlanSBC.com) or by calling 1-888-982-3862. 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.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	In- <u>Network</u> (INN): EE+ 1 Dependent (DEP): Individual (IND) \$125/ Family (FAM) \$250. Out-of- <u>Network</u> (OON): EE+ 1 DEP: IND \$500/ FAM \$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> .
<b>Are there services covered before you meet your deductible?</b>	Yes. <u>Preventive care</u> ; plus INN office visits are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	INN: EE+ 1 DEP: IND 4% of Annual Salary (SAL) \$9,200 Max/ FAM 8% of (SAL) \$18,400 Max. OON: EE+ 1 DEP: IND 4% of SAL \$9,200 Max/ FAM 8% of SAL \$18,400 Max.	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.
<b>What is not included in the out-of-pocket limit?</b>	<u>Premiums</u> , <u>balance-billing</u> 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> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-888-982-3862 for a list of Dow Family Health Center <u>providers</u> .	You pay the least if you use a <u>provider</u> in Dow Family Health Center. You pay more if you use a <u>provider</u> in In- <u>Network 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 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.
<b>Do you need a referral to see a specialist?</b>	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
		Dow Family Health Center (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply; no charge for office laboratory	\$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply; no charge for office laboratory; 15% <u>coinsurance</u> for all other services	30% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply; no charge for office laboratory	\$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply; no charge for office laboratory; 15% <u>coinsurance</u> for all other services	30% <u>coinsurance</u>	None
	<u>Preventive care /screening /immunization</u>	No charge	No charge	No charge	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.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	No charge for laboratory; \$10 <u>copay</u> /visit for x-ray, <u>deductible</u> doesn't apply	No charge for laboratory; 15% <u>coinsurance</u> for x-ray	30% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	\$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply	15% <u>coinsurance</u>	30% <u>coinsurance</u>	None
<b>If you need drugs to treat your illness or condition</b>	Generic drugs	\$2 (bypasses deductible)	20% coinsurance	20% via Paper Claims	Prescription drugs are subject to a Deductible EE only \$100; EE + 1 \$200; (Not combined with Medical) Excludes Mail Claims

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Dow Family Health Center (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
More information about <b>prescription drug coverage</b> is available at <a href="http://www.aetna.com/phaarmacy-insurance/individuals-families">www.aetna.com/phaarmacy-insurance/individuals-families</a>	Preferred brand drugs	\$2 (bypasses deductible)	20% coinsurance	20% via Paper Claims	Prescription drugs are subject to a Deductible EE only \$100; EE + 1 \$200; (Not combined with Medical) Excludes Mail Claims Prescription drugs are subject to a Deductible EE only \$100; EE + 1 \$200; (Not combined with Medical) Excludes Mail Claims. Brand penalty when Non-Preferred brand filled over generic Plus brand coinsurance.. Must fill through CVS Specialty Pharmacy
	Non-preferred brand drugs	\$2 (bypasses deductible)	30% coinsurance	30% via Paper Claims	
	<u>Specialty drugs</u>	Not covered	20% coinsurance Max \$200	20% via Paper Claims	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Not applicable	15% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Physician/surgeon fees	Not applicable	15% <u>coinsurance</u>	30% <u>coinsurance</u>	None
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	15% <u>coinsurance</u> after \$100 <u>copay/visit</u>	15% <u>coinsurance</u> after \$100 <u>copay/visit</u>	15% <u>coinsurance</u> after \$100 <u>copay/visit</u>	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . 30% <u>coinsurance</u> after \$100 <u>copay/visit</u> for non-emergency use out-of- <u>network</u> . 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>Emergency medical transportation</u>	15% <u>coinsurance</u>	15% <u>coinsurance</u>	15% <u>coinsurance</u>	
	<u>Urgent care</u>	Not applicable	\$20 <u>copay/visit</u>	30% <u>coinsurance</u>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Not applicable	15% <u>coinsurance</u> after \$250 <u>copay/stay</u>	30% <u>coinsurance</u>	Max <u>copay</u> /calendar year: \$500 in- <u>network</u> . Penalty of 20% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of- <u>network</u> care.
	Physician/surgeon fees	Not applicable	15% <u>coinsurance</u>	30% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Dow Family Health Center (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not applicable	Office: \$20 <u>copay/visit</u> , <u>deductible</u> doesn't apply; other outpatient services: 15% <u>coinsurance</u>	Office & other outpatient services: 30% <u>coinsurance</u>	None
	Inpatient services	Not applicable	15% <u>coinsurance</u> after \$250 <u>copay/stay</u>	30% <u>coinsurance</u>	Max <u>copay</u> /calendar year: \$500 in-network. Penalty of 20% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.
If you are pregnant	Office visits	No charge	No charge	No charge	Cost sharing does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Max <u>copay</u> /calendar year: \$500 in-network. Penalty of 20% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
	Childbirth/delivery professional services	Not applicable	15% <u>coinsurance</u>	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	Not applicable	15% <u>coinsurance</u> after \$250 <u>copay/stay</u> ; <u>deductible</u> waived for newborn hospital expenses	30% <u>coinsurance</u> ; <u>deductible</u> waived for newborn hospital expenses	
If you need help recovering or have other special health needs	<u>Home health care</u>	Not applicable	15% <u>coinsurance</u>	30% <u>coinsurance</u>	Penalty of 20% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Rehabilitation services</u>	\$10 <u>copay/visit</u> , <u>deductible</u> doesn't apply; Speech Therapy not applicable	15% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Habilitation services</u>	\$10 <u>copay/visit</u> , <u>deductible</u> doesn't apply; Speech Therapy not applicable	15% <u>coinsurance</u>	30% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Dow Family Health Center (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	<u>Skilled nursing care</u>	Not applicable	15% <u>coinsurance</u> after \$250 <u>copay/stay</u>	30% <u>coinsurance</u>	180 days/calendar year for out-of-network care. Max <u>copay</u> /calendar year: \$500 in- <u>network</u> . Penalty of 20% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Durable medical equipment</u>	\$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply	15% <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	No charge	No charge	Penalty of 20% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not applicable	No charge	No charge	1 routine eye exam/calendar year.
	Children's glasses	Not applicable	Not covered	Not covered	Not covered.
	Children's dental check-up	Not applicable	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.)**

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Prescription drugs
- Routine foot care

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

- Bariatric surgery - Travel and Lodging limited to \$10,000 maximum for Institutes of Quality contracted in-network facility only.
- Chiropractic care - 30 visits/calendar year.
- Hearing aids - \$3,000 maximum/36 months.
- Infertility treatment - For more information & exceptions, see policy document provided by your employer or call the number on your ID card.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing - 120-8 hour shifts/calendar year.
- Routine eye care (Adult) - 1 routine eye exam/calendar year.

**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](tel:1-888-982-3862) 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 <http://www.dol.gov/ebsa/healthreform>
- For non-federal governmental group health [plans](#), you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).
- If your coverage is a church [plan](#), church [plans](#) are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

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

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

- 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 1-888-982-3862. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/ebsa/healthreform>
- For non-federal governmental group health [plans](#), you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).
- Additionally, a consumer assistance program can help you file your [appeal](#). Contact information is at: <http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html>.

**Does this plan provide Minimum Essential Coverage? Yes.**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this plan meet Minimum Value Standards? No.**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

To see examples of how this plan might cover costs for a sample medical situation, see the next section

About these Coverage Examples:



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

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

- The plan's overall deductible \$125
- Specialist copayment \$10
- Hospital (facility) coinsurance 15%
- Other coinsurance 15%

This EXAMPLE event includes services like:

- Specialist office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (*ultrasounds and blood work*)
- Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$20
<u>Coinsurance</u>	\$1,500
<i>What isn't covered</i>	
Limits or exclusions	\$70
<b>The total Peg would pay is</b>	<b>\$1,690</b>

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

- The plan's overall deductible \$125
- Specialist copayment \$10
- Hospital (facility) coinsurance 15%
- Other coinsurance 15%

This EXAMPLE event includes services like:

- Primary care physician office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs
- Diabetic supplies (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$4,300
<b>The total Joe would pay is</b>	<b>\$4,400</b>

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

- The plan's overall deductible \$125
- Specialist copayment \$10
- Hospital (facility) coinsurance 15%
- Other coinsurance 15%

This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$50
<u>Coinsurance</u>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$10
<b>The total Mia would pay is</b>	<b>\$460</b>



### 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](mailto:CRCoordinator@aetna.com).

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

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

TTY: 711

**Language Assistance:**

To access language services at no cost to you, call 1-888-982-3862.

- Albanian - Për shërbime përkthimi falas për ju, telefononi 1-888-982-3862.
- Amharic - የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-888-982-3862 ይደውሉ።
- Arabic - للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-888-982-3862
- Armenian - Անվճար լեզվակալան ծառայություններից օգտվելու համար զանգահարեք 1-888-982-3862 հեռախոսահամարով:
- Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya.
- Bantu-Kirundi - Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-888-982-3862.
- Bengali-Bangala - আপনাকে বিনামূল্যে ভাষা পবিকষা পপকে হকয এই নম্বকি পেবযক ান েরন: 1-888-982-3862 |
- Bisayan-Visayan - Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-888-982-3862.
- Burmese - သငှ်အေချဖှ် အေေဟကးေြ မေပးရဲဲ ဘာသာစကားေနှေောငှ်းမ်း ရှိ်ိုငှ် 1-888-982-3862 သိုှ ဖှ်းေခငှ်ိုပါ။
- Catalan - Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-888-982-3862.
- Chamorro - Para un hago' i setbision lengguâhi ni dibâtde para hâgu, âgang 1-888-982-3862.
- Cherokee - Ⴀႃ႗ႃ ႡႣ႗ႃ႗ႃ ႡႣ႗ႃ႗ႃ Ⴁ ႠႣ႗ႃ ႡႣ႗ႃ႗ႃ ႡႣ, ႡႣ႗ႃ႗ႃ႗ႃ 1-888-982-3862.
- Chinese - 如欲使用免費語言服務，請致電 1-888-982-3862.
- Choctaw - Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-888-982-3862.
- Cushite - Tajaajiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-888-982-3862.
- Dutch - Voor gratis toegang tot taaldiensten, bell 1-888-982-3862.
- French - Afin d'accéder aux services langagiers sans frais, composez le 1-888-982-3862.
- French Creole - Pou jwenn sèvis lang gratis, rele 1-888-982-3862.
- German - Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-888-982-3862 an.
- Greek - Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-888-982-3862.
- Gujarati - તમારેકોઇ જાતના ખર્ચવિના ભાષાની સેિાઓની પહોોર માટે, કોલ કરો1-888-982-3862.



- Punjabi - ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-888-982-3862 'ਤੇ ਫੋਨ ਕਰੋ।
- Romanian - Pentru a accesa gratuit serviciile de limbă, apălați 1-888-982-3862.
- Russian - Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-888-982-3862.
- Samoan - Mo le mauaina o auaunaga tau gagana e aunoa ma se tologi, vala'au le 1-888-982-3862.
- Serbo-Croatian - Za besplatne prevodilačke usluge pozovite 1-888-982-3862.
- Spanish - Para acceder a los servicios de idiomas sin costo, llame al 1-888-982-3862.
- Sudanic-Fulfude - Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-888-982-3862.
- Swahili - Kupata huduma za lugha bila malipo kwako, piga 1-888-982-3862.
- Syriac - ܟܝ ܫܒܩܐ, ܟܝ ܟܠ ܝܠܟܝܢܐ ܟܝ ܝܠܟܝܢܐ ܟܝܠܩܝܢܐ ܟܝܠܩܝܢܐ, 1-888-982-3862
- Tagalog - Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-888-982-3862.
- Telugu - మీరు భాష సేవలను ఉచితంగా అందుకునందుకు, 1-888-982-3862 కు కాల్ చేయండి.
- Thai - หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-888-982-3862.
- Tongan - Kapau 'oku ke fiema'u ta'etōtōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-888-982-3862.
- Trukese - Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-888-982-3862.
- Turkish - Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-888-982-3862 numarayı arayın.
- Ukrainian - Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-888-982-3862.
- Urdu - بالقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-888-982-3862 پر بات کریں۔
- Vietnamese - Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-888-982-3862.
- Yiddish - צו צוטריט שפראך באדינונגען אין קיין פרייז צו איר, רופן 1-888-982-3862
- Yoruba - Lati wọnú awọn isẹ èdè l'ọfẹ fun ọ, pe 1-888-982-3862.