Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services PRICERITE : Managed Choice® - Managed Care Silver Plus Plan – APCN +





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 1-866-393-0002. 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 1-866-393-0002 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	In- <u>Network</u> : Individual \$750 / Family \$1,500. Out-of-Network: Individual \$1,250 / Family \$2,500.	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 <u>deductible</u> ?	Yes. Emergency care & <u>prescription drugs</u> ; plus in- <u>network</u> office visits & <u>preventive care</u> 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 <u>https://www.healthcare.gov/coverage/preventive-care-benefits/</u>
Are there other <u>deductible</u> s for specific services?	No.	You don't have to meet deductibles for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In- <u>Network</u> : Individual \$3,000 / Family \$6,000. Out-of-Network: Individual \$5,000 / Family \$10,000.	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</u> <u>limits</u> until the overall family <u>out–of–pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premium</u> s, <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> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <u>www.aetna.com/docfind</u> or call 1-866- 393-0002 for a list of In- <u>network providers</u> .	This <u>plan</u> uses a <u>provider</u> <u>network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's</u> <u>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</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 <u>referral</u> to see a <u>specialist</u> ?	No.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



All **<u>copayment</u>** and <u>**coinsurance**</u> costs shown in this chart are after your <u>**deductible**</u> has been met, if a <u>**deductible**</u> applies.

Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% coinsurance	None	
If you visit a health care <u>provider</u> 's office or clinic	<u>Specialist</u> visit	\$40 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	None	
	Preventive care /screening /immunization	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	Diagnostic test (x-ray, blood work)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None	
li you nave a lest	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	None	
If you need drugs to treat your illness or condition More information	Generic drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$10 for 30 day supply, \$20 for 60 day supply, \$30 for 90 day supply (retail)	50% <u>coinsurance,</u> <u>deductible</u> doesn't apply (retail)	Covers 90 day supply (retail). For ShopRite Pharmacies 90 day supply (1x retail). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No	
about prescription drug coverage is available at <u>www.aetnapharmac</u> y.com/standard	Preferred brand drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$30 for 30 day supply, \$60 for 60 day supply, \$90 for 90 day supply (retail)	50% <u>coinsurance,</u> <u>deductible</u> doesn't apply (retail)	charge for preferred generic FDA-approved women's contraceptives in- <u>network</u> . Your cost will be higher for choosing Brand over Generics; cost difference penalty doesn't apply to <u>out-of-</u> <u>pocket limit</u> .	

	What You Will Pay				
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Non-preferred brand drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$50 for 30 day supply, \$100 for 60 day supply, \$150 for 90 day supply (retail)	50% <u>coinsurance,</u> <u>deductible</u> doesn't apply (retail)		
	Specialty drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$100	50% <u>coinsurance,</u> <u>deductible</u> doesn't apply	Precertification required for coverage.	
lf you have outpatient surgery	Facility fee (e.g., ambulatory surgery center) Physician/surgeon fees	10% <u>coinsurance</u> 10% <u>coinsurance</u>	30% <u>coinsurance</u> 30% <u>coinsurance</u>	None None	
	Emergency room care	\$150 <u>copay</u> /visit	\$150 <u>copay</u> /visit	Out-of- <u>network</u> emergency use paid the same as in-network. No coverage for non-emergency use.	
If you need immediate medical	Emergency medical transportation	\$150 <u>copay</u> /trip	\$150 <u>copay</u> /trip	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . Non-emergency transport: not covered, except if pre-authorized.	
attention	<u>Urgent care</u>	\$40 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	None	
If you have a	Facility fee (e.g., hospital room)	10% <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.	
hospital stay	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None	
If you need mental health, behavioral health, or substance abuse	Outpatient services	Office: \$40 <u>copay</u> /visit, <u>deductible</u> doesn't apply; other outpatient services: no charge	Office & other outpatient services: 30% <u>coinsurance</u>	None	
services	Inpatient services	10% coinsurance	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.	
If you are pregnant	Office visits Childbirth/delivery professional services	No charge 10% <u>coinsurance</u>	30% <u>coinsurance</u> 30% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive</u> <u>services</u> . Maternity care may include tests and	

	What You Will Pay			
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Childbirth/delivery facility services	10% <u>coinsurance,</u> except <u>deductible</u> doesn't apply for newborn hospital expenses	30% <u>coinsurance</u>	services described elsewhere in the SBC (i.e., ultrasound). Penalty of 20% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
	Home health care	10% <u>coinsurance</u>	30% <u>coinsurance</u>	120 visits/calendar year. Penalty of 20% of allowed amount for failure to obtain pre- authorization for out-of-network care.
lf you need help	Rehabilitation services	\$40 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	90 visits/calendar year out-of-network for Physical & Occupational Therapy combined, 90 visits/calendar year out-of-network for Speech Therapy.
recovering or have	Habilitation services	No charge	30% <u>coinsurance</u>	None
other special health needs	Skilled nursing care	10% <u>coinsurance</u>	30% <u>coinsurance</u>	60 days/calendar year. Penalty of 20% of <u>allowed</u> <u>amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Durable medical equipment	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	10% <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.
If your child needs	Children's eye exam	Not covered	Not covered	Not covered.
dental or eye care	Children's glasses	Not covered	Not covered	Not covered.
actual of eye oure	Children's dental check-up	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 eye care (Adult & Child)
 Routine eye care (Adult & Child)

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

 Acupuncture - Limited to adult postoperative medical & dental, chemotherapy & pregnancy nausea, & chronic low back pain. Bariatric surgery 		Chiropractic care Hearing aids - 1 hearing aid to \$1,000 maximum per ear/24 months in- <u>network</u> & 1 hearing aid to \$1,000 maximum per ear/24 months for children up to age 16 out-of- <u>network</u> .	•	Infertility treatment - For more information & exceptions, see policy document provided by your employer or call the number on your ID card. Private-duty nursing - \$10,000 maximum/calendar year.
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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 <u>plan</u> at 1-866-393-0002.
- 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 <u>www.cciio.cms.gov</u>.
- If your coverage is a church <u>plan</u>, church <u>plans</u> 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 <u>Health Insurance Marketplace</u>. For more information about the <u>Marketplace</u>, visit <u>www.HealthCare.gov</u> or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your plan documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. 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 1-866-393-0002. 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 <u>www.cciio.cms.gov</u>.
- Additionally, a consumer assistance program can help you file your <u>appeal</u>. Contact information is at: <u>http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html</u>.

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 <u>plan</u> 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 <u>plan's</u> overall <u>deductible</u>	\$750
Specialist copayment	\$40
Hospital (facility) <u>coinsurance</u>	10%
Other <u>coinsurance</u>	10%

This EXAMPLE event includes services like: Specialist office visits (prenatal care) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and blood work) Specialist visit (anesthesia)

Total Example Cost	\$12,700
In this example, Peg would pay:	
<u>Cost Sharing</u>	
Deductibles	\$750
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$1,100
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$1,920

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

The plan's overall deductible	\$750
Specialist copayment	\$40
Hospital (facility) <u>coinsurance</u>	10%
Other <u>coinsurance</u>	10%

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
In this example, Joe would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$1,000
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,120

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

The <u>plan's</u> overall <u>deductible</u>	\$750
Specialist copayment	\$40
Hospital (facility) <u>coinsurance</u>	10%
Other coinsurance	10%

This EXAMPLE event includes services like:

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

Total Example Cost	\$2,800	
In this example, Mia would pay:		
Cost Sharing		
<u>Deductibles</u>	\$0	
<u>Copayments</u>	\$500	
<u>Coinsurance</u>	\$0	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$500	

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-866-393-0002.

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).

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TTY: 711

Language Assistance:

To access language services at no cost to you, call 1-866-393-0002.

Albanian -	Për shërbime përkthimi falas për ju, telefononi 1-866-393-0002.
Amharic -	የቋንቋ አንልግሎቶችን ያለክፍያ ለማግኝት፣ በ 1-866-393-0002 ይደውሉ፡፡
Arabic -	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء االتصال على الرقم 2002-393-1866
Armenian -	ԱնվՃար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-866-393-0002 հեռախոսահամարով։
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-866-393-0002 tanpa dikenakan biaya.
Bantu-Kirundi -	Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-866-393-0002.
Bengali-Bangala -	
Bisayan-Visayan -	Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-866-393-0002.
Burmese -	သင့္အေနျဖင့္ အခေၾကးေငြ မေပးရပဲ ဘာသာစကားဝန္ေဆာင္မႈမ်ား ရရွိႏုိင္ရန္ 1-866-393-0002 သို႕ ဖုန္းေခၚဆုိပါ။
Catalan -	Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-866-393-0002.
Chamorro -	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-866-393-0002.
Cherokee -	ԱՆՖԴ ՏԵԽԳՅԴ ՆԸՅՐՆԴԴ Ե ԿԼԹԴ ԴԵՐՔԴ ԴԵՐՔԴԴ ԴԵՐՔԴԴ ԴԵՐՔԴԴ ԴԵՐՔԴԴ ԴԵՐՔԴԴ ԴԵՐՔԴԴԴ ԴԵՐՔԴԴԴ ԴԵՐՔԴԴԴԴ ԴԵՐՔԴԴ
Chinese -	如欲使用免費語言服務,請致電 1-866-393-0002.
Choctaw -	Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-866-393-0002.
Cushite -	Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-866-393-0002.
Dutch -	Voor gratis toegang tot taaldiensten, bell 1-866-393-0002.
French -	Afin d'accéder aux services langagiers sans frais, composez le 1-866-393-0002.
French Creole -	Pou jwenn sèvis lang gratis, rele 1-866-393-0002.
German -	Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-866-393-0002 an.
Greek -	Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-866-393-0002.
Gujarati -	તમારેકોઇ જાતના ખર્ચવિના ભાષાની સેિાઓની પહોોંર્ માટે, કોલ કરો1-866-393-0002.

Hawaiian -	No ka wala'au 'ana me ka lawelawe 'ōlelo e kahea aku i kēia helu kelepona 1-866-393-0002. Kāki 'ole 'ia kēia kōkua nei.
Hindi -	,1-866-393-0002
Hmong -	Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-866-393-0002.
lgbo -	lji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ 1-866-393-0002
llocano -	Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-866-393-0002.
Indonesian -	Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-866-393-0002.
Italian -	Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-866-393-0002.
Japanese -	言語サービスを無料でご利用いただくには、1-866-393-0002 までお電話ください。
Karen -	လ၊တါကမာနာ်ကြိုဉ်အတါမာစားအတၢိဖံးတာ်မာတဖဉ်လ၊တအိဉ်ဒီးအမှုးလ၊ကဘဉ်ဟုဉ်အီးအဂ်ီ၊ဘဉ်နဉ် ကိး 1-866-393-0002 တက္နာ.
Korean -	무료 언어 서비스를 이용하려면 1-866-393-0002 번으로 전화해 주십시오.
Kru-Bassa -	M≞dyi wuqu-dù kà kò qò ɓě dyi m⊃ú ń nì Pídyi ní, nìí, qá n⊃⊪ɓà nìà kɛ: 1-866-393-0002
Kurdish -	بۆ دەسېێړ اگەيشتن بە خزمەتگوزارى زمان بەبى تێچوون بۆ تۆ، پەيوەندى بكە بە ژمارەي 2002-393-1866
Laotian -	ເພື່ອເຂົ້າໃຊ້ການບໍລຶການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ1-888-982-3862
Marathi -	व्यव्यव्यव्य व्यव्यव्यव्यव्य व्यव्य व्यव्यव्यव्य व्यव्यव्यव्यव्य,, 1-866-393-0002 वर फोन करा.
Marshallese -	Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-866-393-0002.
Micronesian- Pohnpeyan -	Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-866-393-0002.
Mon-Khmer,	ឌើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-888- 982-3862។
Cambodian - Navajo -	T'áá ni nizaad k'ehjí bee níká a'doowoł doo bą́ą́h ílínígóó kojį' hólne' 1-866-393-0002.
Nepali -	
Nilotic-Dinka -	Të kɔɔr yïn wɛɛ́r̈ de thokic ke cïn wëu kɔr keek tënɔŋ yïn. Ke cɔl kɔc ye kɔc kuɔny ne nɔmba 1-866-393-0002.
Norwegian -	For tilgang til kostnadsfri språktjenester, ring 1-866-393-0002.
Pennsylvania Dutch -	Um Schprooch Services zu griege mitaus Koscht, ruff 1-866-393-0002.
Persian -	بر ای دسترسی به خدمات زبان به طور رایگان، با شماره 393-000-393-1866 تماس بگیرید
Polish -	Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-866-393-0002.
Portuguese -	Para acessar os serviços de idiomas sem custo para você, ligue para 1-866-393-0002.
Punjabi -	

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Romanian -	Pentru a accesa gratuit serviciile de limbă, apelați 1-866-393-0002.
Russian -	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-866-393-0002.
Samoan -	Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-866-393-0002.
Serbo-Croatian -	Za besplatne prevodilačke usluge pozovite 1-866-393-0002.
Spanish -	Para acceder a los servicios de idiomas sin costo, llame al 1-866-393-0002.
Sudanic-Fulfude -	Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-866-393-0002.
Swahili -	Kupata huduma za lugha bila malipo kwako, piga 1-866-393-0002.
Syriac -	:رمحبته، ما بحتكته جنعته ما الما المنهم المعالية المعامين م
Tagalog -	Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-866-393-0002.
Telugu -	2222 222 22222 222222 222222 222220222, 1-866-393-0002 22 2222 22222.
Thai -	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-866-393-0002.
Tongan -	Kapau 'oku ke fiema'u ta'etōtōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-866-393-0002.
Trukese -	Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-866-393-0002.
Turkish -	Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-866-393-0002 numarayı arayın.
Ukrainian -	Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-866-393-0002.
Urdu -	بالقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 3862-982-888-1 پر بات کریں۔
Vietnamese -	Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-866-393-0002
Yiddish -	צו צוטריט שפרַאך בַאדינונגען אין קיין פרייַז צו איר, רופן 1-866-393-0002
Yoruba -	Lati wọnú awọn ise èdè l'ofe fun o, pe 1-866-393-0002.