



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, <https://www.aetnastudenthealth.com/en/school/175363/members.html> or by calling 1-877-480-4161. 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 1-877-480-4161 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	For each Plan Year, <u>In-Network</u> : Individual \$500 / Family \$1,000. <u>Out-of-Network</u> : Individual \$1,000 / Family \$2,000.	Generally, you must pay all of the costs from providers 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 deductible expenses paid by all family members meets the overall family deductible.
<b>Are there services covered before you meet your deductible?</b>	Yes. Emergency care & <u>prescription drugs</u> ; plus <u>in-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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	<u>In-Network</u> : Individual \$7,350 / Family \$14,700. <u>Out-of-Network</u> : Individual \$15,000 / Family \$30,000.	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> limits until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	Premiums, <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover & penalties for failure to obtain pre-authorization 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 <u>network provider</u>?</b>	Yes. See <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-877-480-4161 for a list of <u>in-network</u> providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</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.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</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 In-Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply	40% <u>coinsurance</u>	None
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	40% <u>coinsurance</u> , except no charge for immunizations up to age 6	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition  More information about <u>prescription drug coverage</u> is available at <a href="https://www.aetnastudenthealth.com/en/school/175363/members/prescriptions.html">https://www.aetnastudenthealth.com/en/school/175363/members/prescriptions.html</a>	Generic drugs	<u>Copay/prescription</u> , <u>deductible</u> doesn't apply: \$20 (retail), \$50 (mail order)	40% <u>coinsurance</u> , <u>deductible</u> doesn't apply	Covers 30-day supply (retail), 31-90 day supply (retail & mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in-network.
	Preferred brand drugs	<u>Copay/prescription</u> , <u>deductible</u> doesn't apply: \$40 (retail), \$100 (mail order)	40% <u>coinsurance</u> , <u>deductible</u> doesn't apply	
	Non-preferred generic and brand drugs	<u>Copay/prescription</u> , <u>deductible</u> doesn't apply: \$60 (retail), \$150 (mail order)	40% <u>coinsurance</u> , <u>deductible</u> doesn't apply	
	<u>Specialty</u> drugs	<u>Copay/prescription</u> , <u>deductible</u> doesn't apply: \$20 (retail), \$50 (mail order) for Generic drugs, \$40 (retail), \$100 (mail order) for Preferred brand drugs, \$60 (retail), \$140 (mail order) for Non-preferred brand drugs	40% <u>coinsurance</u> , <u>deductible</u> doesn't apply	
	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you have outpatient surgery	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None

\* For more information about limitations and exceptions, see the plan or policy document at <https://www.aetnastudenthealth.com/en/school/175363/members.html>.

Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u> after \$150 <u>copay/ visit, deductible</u> doesn't apply	20% <u>coinsurance</u> after \$150 <u>copay/ visit, deductible</u> doesn't apply	No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u> after \$150 <u>copay/trip, deductible</u> doesn't apply	20% <u>coinsurance</u> after \$150 <u>copay/trip, deductible</u> doesn't apply	Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care for non-emergency transportation by airplane.
	<u>Urgent care</u>	\$50 <u>copay/ visit, deductible</u> doesn't apply	40% <u>coinsurance</u>	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$30 <u>copay/visit, deductible</u> doesn't apply; other outpatient services: 20% <u>coinsurance</u>	Office & other outpatient services: 40% <u>coinsurance</u>	None
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If you are pregnant	Office visits	No charge	40% <u>coinsurance</u>	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). Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	60 visits/ <u>plan year</u> .
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Includes Physical, Occupational & Speech Therapy.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	25 days/ <u>plan year</u> . Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.

\* For more information about limitations and exceptions, see the plan or policy document at <https://www.aetnastudenthealth.com/en/school/175363/members.html>.

Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If your child needs dental or eye care	Children's eye exam	No charge	40% <u>coinsurance</u>	1 routine eye exam/ <u>plan</u> year. Coverage through end of month turning age 19.
	Children's glasses	No charge	40% <u>coinsurance</u>	1 pair of glasses or lenses/ <u>plan</u> year. Coverage through end of month turning age 19.
	Children's dental check-up	No charge	No charge	Limited to 2 visits every 12 months. Coverage through end of month turning age 19.

#### 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
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Private-duty nursing
- 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.)

- Chiropractic care
- Hearing aids – 1 hearing aid per ear/3 years.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition and fertility preservation.
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) - 1 routine eye exam/plan year.

\* For more information about limitations and exceptions, see the plan or policy document at <https://www.aetnastudenthealth.com/en/school/175363/members.html>.

**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 Texas Department of Insurance, 1-800-252-3439 (Consumer HelpLine), (512) 676-6000 (Local), (800) 578-4677 (Toll-Free), [www.tdi.texas.gov/consumer/get-help-with-an-insurance-complaint.html](http://www.tdi.texas.gov/consumer/get-help-with-an-insurance-complaint.html).

- 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](http://www.dol.gov/ebsa/healthreform).
- For more information on your rights to continue coverage, contact the plan at 1-877-480-4161.
- 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 Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-877-480-4161 or Texas Department of Insurance, 1-800-252-3439 (Consumer HelpLine), (512) 676-6000 (Local), (800) 578-4677 (Toll-Free), [www.tdi.texas.gov/consumer/get-help-with-an-insurance-complaint.html](http://www.tdi.texas.gov/consumer/get-help-with-an-insurance-complaint.html). Additionally, a consumer assistance program can help you file your appeal. Contact Texas Department of Insurance, Consumer Protection, Mail Code 111-1A, 333 Guadalupe, P.O. Box 149091, Austin, TX 78714-9091, Phone toll-free: 1-800-252-3439, <http://www.texashealthoptions.com>, [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov).

#### **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.

#### **Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-480-4161.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-480-4161.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-480-4161.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-877-480-4161.

**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 <u>plan's overall deductible</u>	\$500
■ <u>Specialist copayment</u>	\$30
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	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:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$2,420
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,080</b>

### Managing Joe's Type 2 Diabetes

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

■ The <u>plan's overall deductible</u>	\$500
■ <u>Specialist copayment</u>	\$30
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	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:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$1,700
<u>Coinsurance</u>	\$10
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,230</b>

### Mia's Simple Fracture

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

■ The <u>plan's overall deductible</u>	\$500
■ <u>Specialist copayment</u>	\$30
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	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:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$70
<u>Coinsurance</u>	\$450
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,020</b>

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

## Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-877-480-4161.

## 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 discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides 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: PO Box 24030 Fresno, CA 93779)  
1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705)  
Email: [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 subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates.**

**Language Assistance:**

For language assistance in your language call 1-877-480-4161 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-877-480-4161.
Amharic -	ለኢትዮጵያ አገልግሎት 1-877-480-4161 በነፃ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-877-480-4161
Armenian -	Լեզվի գուցաբերած աջակցության (հայերեն) զանգի 1-877-480-4161 առանց գնուվ:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-877-480-4161 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-877-480-4161 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামূলে 1-877-480-4161-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-877-480-4161 nga walay bayad.
Burmese -	ထွက်နှုန်းဝန်ဆောင်ရေး (မြန်မာဘာသာစကား) ဖြင့် ဘာသာစကားအကျအညိုပုံရန် 1-877-480-4161 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-877-480-4161.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-877-480-4161 sin gåstu.
Cherokee -	Theta Salihi Ahañi Jihosilis 1-877-480-4161 O'oth L AΓoñi JEGPJI HPRTheta.
Chinese -	欲取得繁體中文語言協助，請撥打 1-877-480-4161，無需付費。
Choctaw -	(Chahta) anumpa ya_apela a chi I paya hinla 1-877-480-4161.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-877-480-4161 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-877-480-4161.
French -	Pour une assistance linguistique en français appeler le 1-877-480-4161 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-877-480-4161 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-877-480-4161 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-877-480-4161 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-877-480-4161 પર કોલ કરો.

Hawaiian -	No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-877-480-4161. Kāki ‘ole ‘ia kēia kōkua nei.
Hindi -	<b>हन्दी में भाषा सहायता के लिए, 1-877-480-4161 पर मुफ्त कॉल करें।</b>
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-877-480-4161.
Ibo -	Maka enyemaka asusụ na Igbo kpọọ 1-877-480-4161 na akwughị ụgwọ ọ bụla
Ilocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-877-480-4161 nga awan ti bayadanyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-877-480-4161.
Japanese -	日本語で援助をご希望の方は、1-877-480-4161まで無料でお電話ください。
Karen -	လာဝါမော်ကတိဂျီနီအရီ ကျို့ လို့ 1-877-480-4161 လာဝါဒီးတိလိုက်စွာဘုရား
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-877-480-4161 번으로 전화해 주십시오.
Kru-Bassa -	Be'm'ké gbo-kpá-kpá dyé piidyi qé 'Bássó-wuquún wéé, qá 1-877-480-4161
Kurdish -	برای راهنمایی به زبان فارسی با شماره 1-877-480-4161 به خوراکی یمیوندی بکمن.
Laotian -	ທ້າທ່ານຕົວງານຄວາມຊົວຍໍ້ໃນການແພພາສາລາວ, ກະລຸນາໄທໜາ 1-877-480-4161 ໂດຍບໍ່ແສຍຄ່າໄທ.
Marathi -	कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-877-480-4161 वर फोन करा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-877-480-4161 ilo ejjelok wōnān.
Micronesian- Pohnpeyan -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-877-480-4161 ni sohte isais.
Mon-Khmer, Cambodian -	សមුෂ්‍රප්‍රදීපුයාසාධී ກාසාදුම් සුෂ්ඨුස්ත්‍රික්‍රියාත්මක 1-877-480-4161 ຜ්‍රාග්‍රැම්ක්‍රිස්ථ්‍රීයා
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-877-480-4161
Nepali -	(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1- 877-480-4161 मा फोन गर्नुहोस्।
Nilotic-Dinka -	Tén kuɔɔny ë thok ë Thuɔɔjäŋ col 1-877-480-4161 kecín aycöc.
Norwegian -	For språkassistanse på norsk, ring 1-877-480-4161 kostnadsfritt.
Punjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-877-480-4161 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-877-480-4161 aa. Es Aaruf koschtet nix.
Persian -	برای راهنمایی به زبان فارسی با شماره 1-877-480-4161 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-877-480-4161.

