



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/232088/members.html> or by calling 1-877-626-2308. 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 1-877-626-2308 to request a copy.

Important Questions	Answers	Why This Matters:
<u>What is the overall deductible?</u>	For each <u>Plan Year</u> , <u>In-Network</u> : Individual \$500. <u>Out-of-Network</u> : Individual \$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> .
<u>Are there services covered before you meet your deductible?</u>	Yes. <u>Prescription drugs</u> ; plus <u>in-network 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>
<u>Are there other deductibles for specific services?</u>	No.	You don't have to meet <u>deductibles</u> for specific services.
<u>What is the out-of-pocket limit for this plan?</u>	<u>In-Network</u> : Individual \$7,500. <u>Out-of-Network</u> : Individual \$15,000.	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 limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<u>What is not included in the out-of-pocket limit?</u>	Premiums, <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> .
<u>Will you pay less if you use a network provider?</u>	Yes. See <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-877-626-2308 for a list of <u>in-network providers</u> .	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.
<u>Do you need a referral to see a specialist?</u>	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
		In-Network Provider (You will pay the least)	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	20% <u>coinsurance</u> after \$25 <u>copay/visit</u>	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	20% <u>coinsurance</u> after \$25 <u>copay/visit</u>	40% <u>coinsurance</u>	None
	<u>Preventive care /screening</u> /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	<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/232088/members/prescriptions.html">https://www.aetnastudenthealth.com/en/school/232088/members/prescriptions.html</a>	Generic drugs	<u>Copay/prescription, deductible</u> doesn't apply: \$25 (retail)	30% <u>coinsurance after copay/prescription, deductible</u> doesn't apply: \$25 (retail)	Covers 30-day supply (retail). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives <u>in-network</u> .
	Preferred brand drugs	<u>Copay/prescription, deductible</u> doesn't apply: \$65 (retail)	30% <u>coinsurance after copay/prescription, deductible</u> doesn't apply: \$65 (retail)	
	Non-preferred generic and brand drugs	<u>Copay/prescription, deductible</u> doesn't apply: \$100 (retail)	30% <u>coinsurance after copay/prescription, deductible</u> doesn't apply: \$100 (retail)	
	<u>Specialty drugs</u>	20% <u>coinsurance, deductible</u> doesn't apply	20% <u>coinsurance, deductible</u> doesn't apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	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 [www.aetnastudenthealth.com/en/school/232088/members.html](https://www.aetnastudenthealth.com/en/school/232088/members.html).

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u> after \$200 <u>copay/visit</u>	20% <u>coinsurance</u> after \$200 <u>copay/visit</u>	Out-of-network emergency use paid the same as <u>in-network</u> . No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Out-of-network emergency use paid the same as <u>in-network</u> .
	<u>Urgent care</u>	20% <u>coinsurance</u> after \$25 <u>copay/visit</u>	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> after \$200 <u>copay/stay</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: 20% <u>coinsurance</u> after \$25 <u>copay/visit</u> ; other outpatient services: 20% <u>coinsurance</u>	Office & other outpatient services: 40% <u>coinsurance</u>	None
	Inpatient services	20% <u>coinsurance</u> after \$200 <u>copay/stay</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	30% <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> after \$200 <u>copay/stay</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>	None
	<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>	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.
	<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.

\* For more information about limitations and exceptions, see the plan or policy document at [www.aetnastudenthealth.com/en/school/232088/members.html](http://www.aetnastudenthealth.com/en/school/232088/members.html).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge	30% <u>coinsurance</u>	1 routine eye exam/ <u>plan</u> year. Covered through the end of the month in which the covered person turns age 19.
	Children's glasses	No charge	30% <u>coinsurance</u>	1 pair of glasses or lenses/ <u>plan</u> year. Covered through the end of the month in which the covered person turns age 19.
	Children's dental check-up	No charge	30% <u>coinsurance</u>	Covered through the end of the month in which the covered person turns 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
- Routine eye care (Adult)
- 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/4 years
- Infertility treatment – Limited to the diagnosis & treatment of underlying medical condition.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

\* For more information about limitations and exceptions, see the plan or policy document at [www.aetnastudenthealth.com/en/school/232088/members.html](http://www.aetnastudenthealth.com/en/school/232088/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: Missouri Department of Commerce and Insurance, Harry S. Truman State Office Building, 573-751-4126, Insurance Consumer Hotline: 800-726-7390, <https://insurance.mo.gov/consumers/complaints/index.php>. For more information on your rights to continue coverage, contact the plan at 1-877-626-2308. 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 1-877-626-2308 or Missouri Department of Commerce and Insurance, Harry S. Truman State Office Building, 573-751-4126, Insurance Consumer Hotline: 800-726-7390, <https://insurance.mo.gov/consumers/complaints/index.php>.

**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 1-877-626-2308.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-626-2308.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-626-2308.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-877-626-2308.

*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>	\$25
■ <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*)

<b>Total Example Cost</b>	<b>\$9,930</b>
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$2,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,770</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>	\$25
■ <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*)

<b>Total Example Cost</b>	<b>\$3,580</b>
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$1,400
<u>Coinsurance</u>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,020</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>	\$25
■ <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*)

<b>Total Example Cost</b>	<b>\$1,790</b>
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,010</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 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](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).

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TTY: 711

**Language Assistance:**

To access language services at no cost to you, call 1-877-626-2308.

Albanian -	Për shërbime përkthimi falas për ju, telefononi 1-877-626-2308.
Amharic -	የኢትዮጵያ አገልግሎቶችን የለከናዸ ለማግኘት በ 1-877-626-2308 ይደውሉ::
Arabic -	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء التصال على الرقم 1-877-626-2308
Armenian -	Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-877-626-2308 հեռախոսահամարով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-877-626-2308 tanpa dikenakan biaya.
Bantu-Kirundi -	Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-877-626-2308.
Bengali-Bangala -	আপনাকে বিনামূলক ভাষা পরিকর্মা প্রদান করব এই নম্বরে প্রেরণ করুন: 1-877-626-2308
Bisayan-Visayan -	Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-877-626-2308.
Burmese -	သင့်အောင့်မှု အခေါ်ကုပ္ပါယ် မေးပါ ဘာသာစကားဝန်ဆောင်းမှု ရနိုးရှိနဲ့ 1-877-626-2308 သို့မှ ဖုန်းခေါ်ဆုံးပါ။
Catalan -	Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-877-626-2308.
Chamorro -	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-877-626-2308.
Cherokee -	ᏍᎽᏃᎳ ሪ୍ୟୁୱୁମ୍ୟୁ ማ୍ୟୁୱୁମ୍ୟୁ ማ୍ୟୁୱୁମ୍ୟୁ 1-877-626-2308.
Chinese -	如欲使用免費語言服務，請致電 1-877-626-2308.
Choctaw -	Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-877-626-2308.
Cushite -	Tajaajiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-877-626-2308.
Dutch -	Voor gratis toegang tot taaldiensten, bell 1-877-626-2308.
French -	Afin d'accéder aux services langagiers sans frais, composez le 1-877-626-2308.
French Creole -	Pou jwenn sèvis lang gratis, rele 1-877-626-2308.
German -	Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-877-626-2308 an.
Greek -	Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-877-626-2308.
Gujarati -	તમારેકોઇ જાતના ખર્ચવિના ભાષાની સેટિંગ્ઝની પહોર માટે, કોલ કરો 1-877-626-2308.

Hawaiian -	No ka wala‘au ‘ana me ka lawelawe ‘ōlelo e kahea aku i kēia helu kelepona 1-877-626-2308. Kāki ‘ole ‘ia kēia kōkua nei.
Hindi -	आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए, 1-877-626-2308 पर कॉल करें।
Hmong -	Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-877-626-2308.
Igbo -	Iji nwetaòhèrè na ọru gasị asusụ n'efu, kpọọ 1-877-626-2308
Ilocano -	Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-877-626-2308.
Indonesian -	Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-877-626-2308.
Italian -	Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-877-626-2308.
Japanese -	言語サービスを無料でご利用いただくには、1-877-626-2308までお電話ください。
Karen -	လာတိကမ္မန်ကိုပြုအတိမ္မစာအတိပုံးတိမ္မတဖုန်းတိမ္မတဖုန်းအပူးလာကဘာ့ဟန်အိုးကိုဘာ့န် ကို 1-877-626-2308 တကို။
Korean -	무료 언어 서비스를 이용하려면 1-877-626-2308 번으로 전화해 주십시오.
Kru-Bassa -	Miller diyi wuqu-dù kà kò qò bë dyi móú nì Pídyi ní, níí, qá nòbà nià ke: 1-877-626-2308
Kurdish -	بۇ دەسپىئر اگەيشتن بە خز مەتگۇز ارى زمان بەسىن تىچۇن بۇ تو، پەپۇندى بىكە بە ژمارە 1-877-626-2308
Laotian -	ເພື່ອຂັ້ນໃຈ້າງັນບໍລິການພາກາໄດລປ່ອນລົ່າກັບທ່ານ, ໃຫ້້າທ່ານເປີ 1-877-626-2308
Marathi -	कोणत्याही शलुकालशवाय भाषा सेवा प्राप्त करण्यासाठी,, 1-877-626-2308 वर फोन करा.
Marshallese -	Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-877-626-2308.
Micronesian- Pohnpeyan -	Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-877-626-2308.
Mon-Khmer, Cambodian -	ដើម្បីទទួលបានសេវាគម្ពោះភាសាដែលត្រួតពិនិត្យសម្រាប់លោកអ្នក ស្របខោត្រូវការណ៍លេខ 1-855-821-97204
Navajo -	T'áá ni nizaad k'ehjí bee níká a'doowoł doo báqh ílínígóó koji' hólne' 1-877-626-2308.
Nepali -	निःशुल्क भाषा सेवा प्राप्त गर्ने 1-877-626-2308 मा टेलिफोन गर्नुहोस् ।
Nilotic-Dinka -	Të koor yin wëëř de thokic ke cïn wëu kör keek tënöŋ yin. Ke cö! koc ye koc kuony ne nomba 1-877-626-2308.
Norwegian -	For tilgang til kostnadsfri språktjenester, ring 1-877-626-2308.
Pennsylvania Dutch -	Um Schprooch Services zu griege mitaus Koscht, ruff 1-877-626-2308.
Persian -	برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-877-626-2308 تماس بگیرید.
Polish -	Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-877-626-2308.
Portuguese -	Para acessar os serviços de idiomas sem custo para você, ligue para 1-877-626-2308.

Punjabi -	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-877-626-2308 'ਤੇ ਫੋਨ ਕਰੋ।
Romanian -	Pentru a accesa gratuit serviciile de limbă, apelați 1-877-626-2308.
Russian -	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-877-626-2308.
Samoan -	Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-877-626-2308.
Serbo-Croatian -	Za besplatne prevodilačke usluge pozovite 1-877-626-2308.
Spanish -	Para acceder a los servicios de idiomas sin costo, llame al 1-877-626-2308.
Sudanic-Fulfude -	Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-877-626-2308.
Swahili -	Kupata huduma za lugha bila malipo kwako, piga 1-877-626-2308.
Syriac -	جَلِيلِيَّةٌ، 1-877-626-2308
Tagalog -	Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-877-626-2308.
Telugu -	మీరు భాష స్వలను ఉచితంగా అందుకునందుకు, 1-877-626-2308 కు కాల్ చేయండి.
Thai -	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-877-626-2308.
Tongan -	Kapau 'oku ke fiema'u ta'etōtōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-877-626-2308.
Trukese -	Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-877-626-2308.
Turkish -	Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-877-626-2308 numarayı arayın.
Ukrainian -	Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-877-626-2308.
Urdu -	بالقیمت زبان سے متعلق 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 1-877-626-2308.
Yiddish -	צֹו צוֹטְרִיט שְׁפָרָאַךְ בְּאַדִּינוֹנָגָעָן אַיִן קִיִּין פֿרִיעַץ צֹו אַיִר, רְופָאַן 1-877-626-2308
Yoruba -	Latí wọnú awọn isé èdè l'ofe fun o, pe 1-877-626-2308.