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 1-877-371-2007. 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 1-877-371-2007 to request a copy.

### Important Questions

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>In-Network: Individual $300 / Family $600. Out-of-Network: Individual $750 / Family $1,500.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Prescription drugs; plus in-network office visits &amp; preventive care are covered before you meet your deductible</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a></td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>In-Network: Individual $2,300 / Family $4,600. Out-of-Network: Individual $3,750 / Family $7,500.</td>
<td>The out–of–pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out–of–pocket limits until the overall family out–of–pocket limit has been met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges &amp; health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out–of–pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-877-371-2007 for a list of in-network providers</td>
<td>You pay the least if you use a provider in Designated In-Network Provider. You pay more if you use a provider in Non-Designated In-Network Provider. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Weill Network Provider (You will pay the least)</th>
<th>Network Provider (You will pay more)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>$10 copay/visit, deductible doesn't apply</td>
<td>$20 copay/visit, deductible doesn't apply</td>
<td>30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$10 copay/visit, deductible doesn't apply</td>
<td>$30 copay/visit, deductible doesn't apply</td>
<td>30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td>You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>10% coinsurance for laboratory; $10 copay/visit for x-ray, deductible doesn't apply</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$10 copay/visit, deductible doesn't apply</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic drugs</td>
<td>Not applicable</td>
<td>Copay/prescription, deductible doesn't apply: $5 (retail), $10 (mail order)</td>
<td>Reimbursed 100% of contract rate less copay, deductible doesn't apply</td>
<td>Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs &amp; devices obtainable from a pharmacy, oral &amp; injectable fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-network.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>Not applicable</td>
<td>Copay/prescription, deductible doesn't apply: $30 (retail), $60 (mail order)</td>
<td>Reimbursed 100% of contract rate less copay, deductible doesn't apply</td>
<td></td>
</tr>
</tbody>
</table>

More information about prescription drug coverage is
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
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</thead>
<tbody>
<tr>
<td>available at OptumRx <a href="https://www.optumrx.com/public/landing">https://www.optumrx.com/public/landing</a></td>
<td>Non-preferred brand drugs</td>
<td>Not applicable</td>
<td>Copay/prescription, deductible doesn’t apply: $50 (retail), $90 (mail order)</td>
<td>Reimbursed 100% of contract rate less copay, deductible doesn’t apply</td>
<td>Precertification &amp; step therapy required.</td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>Not applicable</td>
<td>Applicable cost as noted above for generic or brand drugs</td>
<td></td>
<td>Applicable cost as noted above for generic or brand drugs</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td>Paid the same as the Network level of benefits</td>
<td>50% coinsurance for non-emergency use.</td>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td>Non-emergency transport: not covered, except if pre-authorized. 50% coinsurance for non-urgent use.</td>
<td></td>
</tr>
<tr>
<td>Urgent care</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>Pre-authorization required for out-of-network care. None</td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office: $10 copay/visit, deductible doesn’t apply; other outpatient services: no charge</td>
<td>Office: $10 copay/visit, deductible doesn’t apply; other outpatient services: no charge</td>
<td>Office &amp; other outpatient services: 30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Inpatient services</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
<td>Pre-authorization required for out-of-network care.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td>Cost sharing does not apply for preventive services. Maternity care may include tests and services</td>
</tr>
<tr>
<td>Childbirth/delivery professional services</td>
<td>No charge</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Weill Network Provider (You will pay the least)</td>
<td>Network Provider (You will pay more)</td>
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<td>Limitations, Exceptions, &amp; Other Important Information</td>
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<tr>
<td>----------------------</td>
<td>----------------------</td>
<td>---------------------------------</td>
<td>---------------------------------</td>
<td>---------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Childbirth/delivery facility services</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>described elsewhere in the SBC (i.e. ultrasound.) Pre-authorization for out-of-network care may apply.</td>
</tr>
<tr>
<td>Home health care</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>200 visits/calendar year, including private-duty nursing. Pre-authorization required for out-of-network care.</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>60 visits/calendar year for Speech Therapy, but unlimited visits for Autism.</td>
<td></td>
</tr>
<tr>
<td>Habilitation services</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>120 days/calendar year. Pre-authorization required for out-of-network care.</td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse. Pre-authorization required for out-of-network care.</td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice services</td>
<td>0% coinsurance</td>
<td>0% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>$10 copay/visit, deductible doesn’t apply</td>
<td>$30 copay/visit, deductible doesn’t apply</td>
<td>30% coinsurance</td>
<td>1 routine eye exam/calendar year.</td>
</tr>
<tr>
<td>Children's glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Children's dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered.</td>
</tr>
</tbody>
</table>

**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)
- Long-term care
- Glasses (Adult & Child)
- Routine foot care
- Weight loss programs - Except for required preventive services.
Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)

- Acupuncture (When rendered by an MD)
- Bariatric surgery - Limited to designated in-network providers.
- Transgender surgery
- Chiropractic care - 36 visits/calendar year.
- Hearing aids - $3,000 maximum/3 years.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing - 200 visits/calendar year combined with home health care.
- Routine eye care (Adult & Child) - 1 routine eye exam/calendar year.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Artificial insemination & ovulation induction: 6 combined cycles/lifetime. Advanced reproductive technology: 3 cycles/lifetime & $20,000 maximum/lifetime combined with comprehensive infertility services.
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage:
There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For more information on your rights to continue coverage, contact the plan at 1-800-231-7729.
- 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/ebia/health改革
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

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

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

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-800-231-7729.
- 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/ebia/health改革
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at:

**Does this plan provide Minimum Essential Coverage? Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet Minimum Value Standards? Yes.**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.
About these Coverage Examples:

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

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

- The plan's overall deductible: **$300**
- Specialist copayment: **$10**
- Hospital (facility) coinsurance: 10%
- Other coinsurance: 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**: $12,800

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$300</td>
</tr>
<tr>
<td>Copayments</td>
<td>$50</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,200</td>
</tr>
</tbody>
</table>

**What isn't covered**

- Limits or exclusions: $60
- The total Peg would pay is: $1,610

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

- The plan's overall deductible: **$300**
- Specialist copayment: **$10**
- Hospital (facility) coinsurance: 10%
- Other coinsurance: 10%

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**: $7,400

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$100</td>
</tr>
<tr>
<td>Copayments</td>
<td>$800</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn't covered**

- Limits or exclusions: $20
- The total Joe would pay is: $920

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

- The plan's overall deductible: **$300**
- Specialist copayment: **$10**
- Hospital (facility) coinsurance: 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**: $1,900

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$300</td>
</tr>
<tr>
<td>Copayments</td>
<td>$20</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$100</td>
</tr>
</tbody>
</table>

**What isn't covered**

- Limits or exclusions: $0
- The total Mia would pay is: $420

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, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

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

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates.
TTY: 711

**Language Assistance:**

For language assistance in your language call 1-800-231-7729 at no cost.

- **Albanian** - Për asistencë në gjuhën shqipe telefononi falas në 1-800-231-7729.
- **Amharic** - እንግወ ከማነ ናለምር ከ 1-800-231-7729 በተ. ከማወረ ከማኞቹ
- **Arabic** - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-231-7729
- **Armenian** - Ներկայցնեք նշանակության (հայերեն) ջանկյություն 1-800-231-7729 կատարեք գումար:
- **Bahasa Indonesia** - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-231-7729 tanpa dikenakan biaya.
- **Bantu-Kirundi** - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-800-231-7729 ku busa
- **Bengali-Bangala** - বাংলায় ভাষা সহায়তার জন্য বিনামূল্য 1-800-231-7729-তে কল করুন।
- **Bisayan-Visayan** - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-231-7729 nga walay bayad.
- **Burmese** - မြန်မာဘာသာ အရောင်း အဖွဲ့အစည်းနှင့် 1-800-231-7729 ကြည့်ရှုနိုင်ပါသည်။
- **Catalan** - Per rebre assistència en (català), truqui al número gratuït 1-800-231-7729.
- **Chamorro** - Para ayuda gi fino' (Chamoru), ågang 1-800-231-7729 sin gåstu.
- **Cherokee** - ᎠᏍᎬᏲ ᎠᏣᎳᎴ ᎠᏂᎨᏙᏗ ᎠᎦᏬᏲᏙᏗ 1-800-231-7729 ᎨᏣᎷ ᏲᏣᏨ ᏪᏗᎵ.érique. hEOS.
- **Chinese** - 欲取得繁體中文語言協助，請撥打 1-800-231-7729，無需付費。
- **Choctaw** - (Chahta) anumpa ya apela a chi l paya hinla 1-800-231-7729.
- **Cushite** - Gargaarsa afaan Oromiffa hi kuu argach uuf lakkokkofsa bilbilaa 1-800-231-7729 IRRatti bilisaan bilbilaa.
- **Dutch** - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-231-7729.
- **French** - Pour une assistance linguistique en français appeler le 1-800-231-7729 sans frais.
- **French Creole** - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-231-7729 gratis.
- **German** - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-231-7729 an.
- **Greek** - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-231-7729 χωρίς χρέωση.
- **Gujarati** - ગુજરાતીમાં લાઇફ સહાય માટે કોઈ પણ અર્થ વચ્ચે 1-800-231-7729 પર કોલ કરો.
- **Hawaiian** - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-800-231-7729. Kākī ‘ole ‘ia kēia kōkua nei.
Hindi - हिन्दी में भाषा सहायता के लिए, 1-800-231-7729 पर मुफ्त कॉल करें।

Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-231-7729.

Ibo - Maka enyemaka asuşụ na Igbo kpọọ 1-800-231-7729 na akwughị ụgwọ ọ bụla

Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-231-7729 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, puó chiamare gratuitamente 1-800-231-7729.

Japanese - 日本語で援助をご希望の方は、1-800-231-7729まで無料でお電話ください。

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-231-7729 번으로 전화해 주십시오.

Kru-Bassa - Bé m'ké gbo-kpá-kpá dyé pidyi dé Basso-wuqueen wèe, ṭà 1-800-231-7729

Kurdish - برای راهنمایی به زبان فارسی با شماره 1-800-231-7729 به خوزستانی یا پایتخت پیام بکن.

Laotian - 1 -800-231-7729

Marathi - कोणत्याह� कश्लका भाषा सेवा प्राप्त करण्यासाठ�, 1-800-231-7729 वर फोन करा.

Marshallese - Nan bok jipañ ilo Kajin Majol, kallok 1-800-231-7729 ilo ejjelok wönän.

Mon-Khmer, Cambodian - 1-800-231-7729

Navajo - T'áá shi shizaad k'ehjí bee shiká a'doowol nínìzingo Diné k'ehjí kojí' t'áá jiík'e hólne' 1-800-231-7729

Nepali - (नेपाली) मा नि:शुल्क भाषा सहायता पाउनका लागि 1-800-231-7729 मा फोन गर्नुहोस्।

Nilotic-Dinka - Tën kuoony ë thok ë Thuonjän col 1-800-231-7729 kecín ayoc.

Norwegian - For språkassistanse på norsk, ring 1-800-231-7729 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਲਈ, 1-800-231-7729 ਵਿੱਚ ਫੋਨ ਕੋਹੋ।

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-800-231-7729 aa. Es Aaruf koschtet nix.

Persian - برای راهنمایی به زبان فارسی با شماره 1-800-231-7729 بدون هیچ هزینه ای تماس بگیرید. انگلیسی

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-231-7729.

Portuguese - Para obter assistência linguística em português ligue para o 1-800-231-7729 gratuitamente.

Romanian - Pentru asistenţă lingvistică în româneşte telefonaţi la numărul gratuit 1-800-231-7729
Чтобы получить помощь русскоговорящего переводчика, позвоните по бесплатному номеру 1-800-231-7729.