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.

<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>
<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>
<td>Out-of-Network Provider (You will pay the most)</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-----------------------------------------------</td>
<td>-------------------------------------</td>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------------</td>
</tr>
<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>Copay/prescription, deductible doesn't apply: $50 (retail), $90 (mail order)</td>
<td>Applicable cost as noted above for generic or brand drugs</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></td>
<td></td>
<td></td>
<td>None</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></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>None</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></td>
<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.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>50% coinsurance for non-urgent use.</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.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>None</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></td>
<td>Inpatient services</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td>30% coinsurance</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></td>
<td>Childbirth/delivery professional services</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>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>------------------</td>
<td>--------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Weill Network Provider (You will pay the least)</td>
<td>Network Provider (You will pay more)</td>
<td>Out-of-Network Provider (You will pay the most)</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></td>
<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>
</tr>
<tr>
<td></td>
<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>
</tr>
<tr>
<td></td>
<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>
</tr>
<tr>
<td></td>
<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>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>0% coinsurance</td>
<td>0% coinsurance</td>
<td>30% coinsurance</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></td>
<td>Children's glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered.</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</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:

- 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.

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/ebus/healthreform](http://www.dol.gov/ebus/healthreform)
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cclio.cms.gov](http://www.cclio.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 1-800-231-7729.
- 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/ebus/healthreform](http://www.dol.gov/ebus/healthreform)
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cclio.cms.gov](http://www.cclio.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*)

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$12,800</th>
</tr>
</thead>
<tbody>
<tr>
<td>In this example, Peg would pay:</td>
<td></td>
</tr>
<tr>
<td>Cost Sharing</td>
<td></td>
</tr>
<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>
<tr>
<td>What isn't covered</td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$60</td>
</tr>
<tr>
<td>The total Peg would pay is</td>
<td>$1,610</td>
</tr>
</tbody>
</table>

### 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*)

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$7,400</th>
</tr>
</thead>
<tbody>
<tr>
<td>In this example, Joe would pay:</td>
<td></td>
</tr>
<tr>
<td>Cost Sharing</td>
<td></td>
</tr>
<tr>
<td>Deductibles</td>
<td>$100</td>
</tr>
<tr>
<td>Copayments</td>
<td>$800</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td>What isn't covered</td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$20</td>
</tr>
<tr>
<td>The total Joe would pay is</td>
<td>$920</td>
</tr>
</tbody>
</table>

### 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*)

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$1,900</th>
</tr>
</thead>
<tbody>
<tr>
<td>In this example, Mia would pay:</td>
<td></td>
</tr>
<tr>
<td>Cost Sharing</td>
<td></td>
</tr>
<tr>
<td>Deductibles</td>
<td>$300</td>
</tr>
<tr>
<td>Copayments</td>
<td>$20</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$100</td>
</tr>
<tr>
<td>What isn't covered</td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$0</td>
</tr>
<tr>
<td>The total Mia would pay is</td>
<td>$420</td>
</tr>
</tbody>
</table>

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**
- እንግዳን ከንኩ ከ ከንኩ ለ1-800-231-7729 ዋና ይመለከት

**Arabic**
- للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-231-7729

**Armenian**
- Ներկայացնում է լեզվի ցուցաբերած աջակցության (հայերեն) ջարդար 1-800-231-7729 աննալ գնով:

**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 বিনামূল্যে 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**
- 1-800-231-7729

**Catalan**
- Per rebre assistència en (català), truqui al número gratuït 1-800-231-7729.

**Chamorro**
- Para ayuda gi fino' (Chamoru), âgang 1-800-231-7729 sin gåstu.

**Cherokee**
- ᎠᏂᎩᏍᏗ ᎫᏣᎳᎩ ᎤᏪᏝᏗ 1-800-231-7729 砣Ꮳ 瘩ᏥᎾ ᎥᎩ ᎮᎨᏗ 砣ᏨᏝᏗ ᎮᏣ ᏣᏣ ᎧᏣ ᏞᏣ 砣ᏪᏣ ᏣᏣ 砣Ꮳ ᏣᏣ ᏣᏣ

**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 i paya hinla 1-800-231-7729.

**Cushite**
- Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsaa 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 ભાષાની સહાય માટે કોઈ પણ અરજ વગર 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. Kāki ‘ole ‘ia kēia kōkua nei.
For assistance in Hindi, call 1-800-231-7729.

For Hmong assistance, call 1-800-231-7729.

For Ibo, call 1-800-231-7729.

For Ilocano assistance, call 1-800-231-7729.

For Italian assistance, call 1-800-231-7729.

For Japanese assistance, call 1-800-231-7729.

For Karen assistance, call 1-800-231-7729.

For Korean assistance, call 1-800-231-7729.

For Kru-Bassa assistance, call 1-800-231-7729.

For Kurdish assistance, call 1-800-231-7729.

For Laotian assistance, call 1-800-231-7729.

For Marathi assistance, call 1-800-231-7729.

For Marshallese assistance, call 1-800-231-7729.

For Micronesian-Pohnpeyan assistance, call 1-800-231-7729.

For Mon-Khmer, Cambodian assistance, call 1-800-231-7729.

For Navajo assistance, call 1-800-231-7729.

For Nepali assistance, call 1-800-231-7729.

For Nilotic-Dinka assistance, call 1-800-231-7729.

For Norwegian assistance, call 1-800-231-7729.

For Panjabi assistance, call 1-800-231-7729.

For Pennsylvania Dutch assistance, call 1-800-231-7729.

For Persian assistance, call 1-800-231-7729.

For Polish assistance, call 1-800-231-7729.

For Portuguese assistance, call 1-800-231-7729.

For Romanian assistance, call 1-800-231-7729.
1-800-231-7729

Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-231-7729.

Samoan - Mo fesoasoani tau gagana le Gagana Samoa vala'au le 1-800-231-7729 e aunoa ma se totogi.

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-231-7729.

Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-800-231-7729.

Sudanic-Fulfude - Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-800-231-7729. Njodi woo fawaaki on.

Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-231-7729 bila malipo.

Syriac - 1-800-231-7729

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-231-7729 nang walang bayad.

Telugu - 1-800-231-7729 క్రమాన్ని అంచన.

Thai - สําหรับความช่วยเหลือทางด้านภาษาเป็นภาษาไทย โทร 1-800-231-7729 ฟรีไม่มีค่าใช้จ่าย

Tongan - Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-800-231-7729 ‘o ‘ikai hā ōtōngi.

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-800-231-7729 nge esapw kamé ngonuk.

Turkish - (Dil) çağrı dil yardım için. Hiçbir ücret ödeden 1-800-231-7729.

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-231-7729.

Urdu - 1-800-231-7729

Vietnamese - Để được hỗ trợ ngôn ngữ (ngôn ngữ), hãy gọi miễn phí đến số 1-800-231-7729.

Yiddish - 1-800-231-7729 פאַר פּאָזמען רילק אַ יידיש ריין

Yoruba - Fún irànìlọwọ nípa èdè (Yorùbá) pe 1-800-231-7729 lái san owó kankan rárá.