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.aetna.com/sbcssearch/getpolicydocs?u=082200-100020-032102](https://www.aetna.com/sbcssearch/getpolicydocs?u=082200-100020-032102) or by calling 1-800-370-4526. 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/](https://www.healthcare.gov/sbc-glossary/) or call 1-800-370-4526 to request a copy.

### Important Questions

| What is the overall deductible? | $0. | See the Common Medical Events chart below for your costs for services this plan covers. |
| Are there services covered before you meet your deductible? | No. | You will have to meet the deductible before the plan pays for any services. |
| Are there other deductibles for specific services? | No. | You don’t have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan? | In-Network: Out-of-Network Individual $3,500 / Family $9,400, Prescription drugs: Individual $3,100 / Family $3,800. | 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. |
| What is not included in the out-of-pocket limit? | Premiums, balance-billing charges & health care this plan doesn’t cover. | Even though you pay these expenses, they don’t count toward the out-of-pocket limit. |
| Will you pay less if you use a network provider? | Yes. See [http://www.aetna.com/docfind](http://www.aetna.com/docfind) or call 1-800-370-4526 for a list of in-network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan’s network. 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. |
| Do you need a referral to see a specialist? | No. | You can see the specialist you choose without a referral. |
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>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>In-Network Provider (You will pay the least) $10 copay/visit</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>Out-of-Network Provider (You will pay the most) Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care /screening /immunization</td>
<td>No charge</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>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No charge</td>
<td>None</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>Copay/prescription: $20 (retail &amp; mail order) Not covered</td>
<td>Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs &amp; devices obtainable from a pharmacy, oral fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-network.</td>
</tr>
<tr>
<td>More information about <a href="http://www.aetnapharmacy.com/standardoptoutaetna">prescription drug coverage</a> is available at <a href="http://www.aetnapharmacy.com/standardoptoutaetna">www.aetnapharmacy.com/standardoptoutaetna</a></td>
<td>Preferred brand drugs</td>
<td>Copay/prescription: $40 (retail &amp; mail order) Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>Copay/prescription: $55 (retail &amp; mail order) Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Applicable cost as noted above for generic or brand drugs</td>
<td>First prescription fill at a retail pharmacy or specialty pharmacy. Subsequent fills must be through the Aetna Specialty Pharmacy Network. Precertification required for coverage.</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$50 copay/visit</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>None</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$100 copay/visit</td>
<td>No coverage for non-emergency use.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No charge</td>
<td>Non-emergency transport: not covered, except if pre-authorized.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$20 copay/visit</td>
<td>No coverage for non-urgent use.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$100 copay/stay</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>None</td>
</tr>
</tbody>
</table>

Published: 10/22/2021
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>In-Network Provider (You will pay the least): Office: $5 copay/visit; other outpatient services: no charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>Out±of±Network Provider (You will pay the most): $100 copay/stay</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>$20 copay/pregnancy</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$100 copay/stay</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$10 copay/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>$100 copay/stay</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>50% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>$10 copay/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Cosmetic surgery</td>
</tr>
<tr>
<td>• Dental care (Adult &amp; Child)</td>
</tr>
<tr>
<td>• Hearing aids</td>
</tr>
<tr>
<td>• Long-term care</td>
</tr>
<tr>
<td>• Non-emergency care when traveling outside the U.S.</td>
</tr>
<tr>
<td>• Private-duty nursing</td>
</tr>
<tr>
<td>• Routine foot care</td>
</tr>
<tr>
<td>• Weight loss programs - Except for required preventive services.</td>
</tr>
</tbody>
</table>
Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)

- Acupuncture - 10 visits/calendar year for disease, injury & chronic pain.
- Bariatric surgery
- Chiropractic care - 20 visits/calendar year.
- Routine eye care (Adult) - 1 routine eye exam/24 months.

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: The District of Columbia Department of Insurance, Securities and Banking, (202) 727-8000, TTY: 711, http://disb.dc.gov/.

- 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.
- For more information on your rights to continue coverage, contact the plan at 1-800-370-4526.
- 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:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general toll free number at 1-800-370-4526. 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.
- 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 Office of Health Care Ombudsman, One Judiciary Square, 441 4th Street, NW, 250 North Washington, DC 20001, Phone: (202) 724-7491, TTY: 711, https://healthcareombudsman.dc.gov/, healthcareombudsman@dc.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.

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: $0
- Specialist copayment: $20
- Hospital (facility) copayment: $100
- Other copayment: $0

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>$0</th>
<th>Copayments</th>
<th>$100</th>
<th>Coinsurance</th>
<th>$0</th>
</tr>
</thead>
<tbody>
<tr>
<td>What isn't covered</td>
<td>Limits or exclusions</td>
<td>$60</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The total Peg would pay is: $160

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

- The plan’s overall deductible: $0
- Specialist copayment: $20
- Hospital (facility) copayment: $100
- Other copayment: $0

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>$0</th>
<th>Copayments</th>
<th>$1,200</th>
<th>Coinsurance</th>
<th>$0</th>
</tr>
</thead>
<tbody>
<tr>
<td>What isn't covered</td>
<td>Limits or exclusions</td>
<td>$20</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The total Joe would pay is: $1,220

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

- The plan’s overall deductible: $0
- Specialist copayment: $20
- Hospital (facility) copayment: $100
- Other copayment: $0

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>$0</th>
<th>Copayments</th>
<th>$200</th>
<th>Coinsurance</th>
<th>$0</th>
</tr>
</thead>
<tbody>
<tr>
<td>What isn't covered</td>
<td>Limits or exclusions</td>
<td>$0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The total Mia would pay is: $200

Note: These numbers assume the patient does not participate in the plan’s wellness program. If you participate in the plan’s wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-370-4526.

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

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**Assistive Technology**

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-370-4526.

**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), CRCordinator@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 1-800-370-4526 at no cost.

Albanian - Për asistencë në gjihuëng shqipe telefononi falas në 1-800-370-4526.

Amharic - እንደሚሰጡ እንደ እንደር እን 1-800-370-4526 እና የደጋጋ ከethical.

Arabic - للمساعدة في (اللغة العربية)، الوجاه الاتصال على الرقم المجاني 1-800-370-4526.

Armenian - Հերթեր նմանատիպ արաբական հաշվին (հաշվեր) կազմեք 1-800-370-4526 Մենք կպահանջ.

Bahasa-Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.

Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-800-370-4526 ku busa.

Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-800-370-4526 কল করুন।

Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-370-4526 nga walay bayad.

Burmese - 1-800-370-4526

Catalan - Per rebre assistència en (català), truqui al número gratuito 1-800-370-4526.

Chamorro - Para ayuda gi fino’ (Chamoru), ågang 1-800-370-4526 sin gástu.

Chinese - 欲取得繁體中文語言協助，請撥打 1-800-370-4526，無需付費。

Choctaw - (Chahta) anumpa ya aplea a chi l paya hinla 1-800-370-4526.

Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-800-370-4526 irratti bilisaan bilbilaa.

Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-370-4526.

French - Pour une assistance linguistique en français appeler le 1-800-370-4526 sans frais.

French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-370-4526 gratis.

German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-370-4526 an.

Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-370-4526 χωρίς χρέωση.

Gujarati - ગુજરાતીમાં સહાય માટે કોઈ પણ પરસ્પર વાગ્ય 1-800-370-4526 પર કોલ કરો.
Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-800-370-4526. Kāki ‘ole ‘ia kēia kōkua nei.

Hindi - हिन्दी में भाषा सहायता के लिए, 1-800-370-4526 पर मुफ्त कॉल करें।

Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-370-4526.

Ibo - Maka enyemaka asụsụ na Igbo kpọọ 1-800-370-4526 na akwụgwị ụgbọ ọ bụla

Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-370-4526 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, puo chiamare gratuitamente 1-800-370-4526.

Japanese - 日本語で援助をご希望の方は、1-800-370-4526 まで無料でお電話ください。

Karen - ვინართქმის ურთიერთობის წყარო აქვთ: 1-800-370-4526 ვინართქმის ურთიერთობის წყარო

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-370-4526 번으로 전화해 주십시오.

Kurdish - 1-800-370-4526

Laotian -ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ຫໍາກ່າວໂທຫາ 1-800-370-4526 ຂໍ້ມູນບໍ່ເສຍຄ່າໂທ.

Marathi - कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-800-370-4526 वर फोन करा.

Marshallese - Ñan bök jipañ ilo Kajin Majol, kallok 1-800-370-4526 ilo ejjelok wönän.

Micronesian - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-370-4526 ni sohte isais.

Mon-Khmer - នាងប្រឈមប្រុងការប្រឈម ប្រុង្គារ ត្រូវបានប្រឈមនៅក្នុងដំបូង 1-800-370-4526 ការជាតិនៅក្នុងដំបូង។

Navajo - T'áá shi shizaad k'ehji bee shiká a'doowol ninízingo Diné k'ehji koji t'áá jiik'e hólne' 1-800-370-4526

Nepali - (नेपाली) मा निश्चित भाषा सहायता पाउनका लागि 1-800-370-4526 मा फोन गर्नुहोस्।

Nilotic-Dinka - Tên kuocny ê thok ê Thuenjâŋ col 1-800-370-4526 kecin ayòc.

Norwegian - For språkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਲਈ, 1-800-370-4526 ਉੱਤੇ ਭੁਲਾਉ ਬਾਲਤੀ।

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-800-370-4526 aa. Es Aaruf koschtet nix.
Persian - برای راهنمایی به زبان فارسی با شماره 26-1-800-370-4526-1700-370-4526-1-370-4526 بیان هستیه ای تأسیس گیرید. اینگلیسی
Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-370-4526.
Portuguese - Para obter assistência linguística em português ligue para o 1-800-370-4526 gratuitamente.
Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-800-370-4526.
Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-370-4526.
Samoan - Mo fesoasoani tau gagana i le Gagana Samoa vala’au le 1-800-370-4526 e aunoa ma se totojì.
Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatnim brojem 1-800-370-4526.
Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-800-370-4526.
Sudanese-Fulfude - Fii yo on hebu balal e ko yowitii e haala Pular nodde e oo numero doo 1-800-370-4526 Njodi woo fawaaki on.
Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-370-4526 bila malipo.
Syriac - ـاـشـئـتـيـنـا ـتـهـبـتـيـنـا ـلـوـسـتـيـنـا ـكـكـيـتـيـنـا ـتـهـبـتـيـنـا 1-800-370-4526 ـشـتـهـتـيـنـا ـفـمـلـتـيـنـا.
Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-370-4526 nang walang bayad.
Telugu - భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-800-370-4526 కు కాల్చేయండి. (తెలుగు)
Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็นภาษาไทยโทร 1-800-370-4526 ฟรีไม่มีค่าใช้จ่าย.
Tongan - Kapau ‘oku fiema’u hā tokoni ‘i he lea faka-Tonga telefoni 1-800-370-4526 ‘o ‘ikai hā tōtōngi.
Trukese - Ren āninnisin chiakū ren (Kapasen Chuuk) kopwe kēkkērī 1-800-370-4526 nge esapw kamē ngonuk.
Turkish - (Dil) çağrı dil yardım için. Hiçbir ücret ödemenin 1-800-370-4526.
Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-370-4526.
Urdu - بلاقیزمت یہ بے منعت، خدمات حاضر کرے کمی لوی، 26-1-800-370-4526-1-800-370-4526-1-800-370-4526.
Vietnamese - Để được hỗ trợ ngôn ngữ (ngôn ngữ), hãy gọi miễn phí đến số 1-800-370-4526.
Yiddish - פאר שערורך בין איזיש תוף 1-800-370-4526.
Yoruba - Fún iránïwọ nípa èdè (Yorù́bá) pe 1-800-370-4526 lài san owó kankan rárá.