



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, visit www.HealthReformPlanSBC.com or call 1-800-367-3636. 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 1-800-367-3636 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	In-Network: EE Only \$1,500; EE+ Family \$3,000. Out-of-Network: EE Only \$1,500; EE+ Family \$3,000.	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 policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	Yes. In-network <u>preventive care</u> is 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 https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	In-Network: EE Only \$5,650; EE+ Family: Individual \$5,650/ Family \$11,300. Out-of-Network: EE Only \$5,650; EE+ Family: Individual \$5,650/ Family \$11,300.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. Under a family plan, each person's individual claims count toward the family out-of-pocket maximum. After a person meets the individual out-of-pocket maximum, their expenses will be covered at 100%.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, health care not covered under this <u>plan</u> & 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> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.trscarestandardaetna.com or call 1-800-367-3636 for a list of in-network <u>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.
Do you need a <u>referral</u> to see a <u>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	Network Provider Not Available	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you visit a health care provider's office or clinic	<u>Specialist</u> visit	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you visit a health care provider's office or clinic	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	20% <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>	20% <u>coinsurance</u>	None
If you have a test	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition <u>Prescription drug coverage</u> is administered by CVS Caremark More information about <u>prescription drug coverage</u> is available at www.caremark.com	Generic drugs	20% <u>coinsurance</u> (retail & mail order or Retail Plus)	20% <u>coinsurance</u> (retail & mail order or Retail Plus)	Covers 31 day supply (retail), 60-90 day supply (mail order or Retail-Plus). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-network. Precertification required. Step therapy required. <u>Deductible</u> does not apply to specific generic preventive medicines. If you utilize a non-participating pharmacy or a network pharmacy that will not file the electronic claim, you must file a direct claim with CVS Caremark. You will be responsible for any cost differences between the pharmacy charge and the plan reimbursement.
If you need drugs to treat your illness or condition. <u>Prescription drug coverage</u> is administered by CVS Caremark. More information about <u>prescription drug coverage</u> is available at www.caremark.com	Preferred brand drugs	20% <u>coinsurance</u> (retail & mail order or Retail Plus)	20% <u>coinsurance</u> (retail & mail order or Retail Plus)	Covers 31 day supply (retail), 32-90 day supply (mail order or Retail-Plus). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-network. Precertification required. Step therapy required. <u>Deductible</u> does not apply to specific generic preventive medicines.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider	Network Provider Not Available	
If you need drugs to treat your illness or condition. <u>Prescription drug coverage</u> is administered by CVS Caremark. More information about <u>prescription drug coverage</u> is available at www.caremark.com	Non-preferred brand drugs	20% <u>coinsurance</u> (retail & mail order or Retail Plus)	20% <u>coinsurance</u> (retail & mail order or Retail Plus)	Covers 31 day supply (retail), 32-90 day supply (mail order or Retail-Plus). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for preferred generic FDA-approved women's contraceptives <u>in-network</u> . Precertification required. Step therapy required. <u>Deductible</u> does not apply to specific generic preventive medicines.
If you need drugs to treat your illness or condition <u>Prescription drug coverage</u> is administered by CVS Caremark. More information about <u>prescription drug coverage</u> is available at www.caremark.com	<u>Specialty drugs</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	All prescriptions must be filled through the Caremark Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you have outpatient surgery	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Urgent care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
If you have a hospital stay	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: 20% <u>coinsurance</u>	Office & other outpatient services: 20% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider	Network Provider Not Available	
If you need mental health, behavioral health, or substance abuse services	Inpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
If you are pregnant	Office visits	No charge	20% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for certain <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
If you are pregnant	Childbirth/delivery professional services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for certain <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
If you are pregnant	Childbirth/delivery facility services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for certain <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	120 visits/calendar year combined with private-duty nursing.
If you need help recovering or have other special health needs	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you need help recovering or have other special health needs	<u>Habilitation services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Limited to the treatment of Autism.
If you need help recovering or have other special health needs	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	365 days/stay. Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
If you need help recovering or have other special health needs	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider	Network Provider Not Available	
If you need help recovering or have other special health needs	<u>Hospice services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered.
If your child needs dental or eye care	Children's glasses	Not covered	Not covered	Not covered.
If your child needs dental or eye care	Children's dental check-up	Not covered	Not covered	Not covered.

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
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Routine eye care (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.)

- Bariatric surgery
- Chiropractic care - 20 visits/calendar year.
- Hearing aids - 1 hearing aid per ear/3 years up to age 19.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing - 120 visits/calendar year combined with private-duty nursing.

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:

- 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 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 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 1-800-367-3636.
- 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 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: <http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html>.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have **Minimum Essential Coverage** for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standard? 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 <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist</u> <u>copayment</u>	20%
■ Hospital (facility) <u>copayment</u>	20%
■ Other <u>copayment</u>	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
In this example, Peg would pay:	
<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$2,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,760

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist</u> <u>copayment</u>	20%
■ Hospital (facility) <u>copayment</u>	20%
■ Other <u>copayment</u>	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
In this example, Joe would pay:	
<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,720

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist</u> <u>copayment</u>	20%
■ Hospital (facility) <u>copayment</u>	20%
■ Other <u>copayment</u>	20%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
In this example, Mia would pay:	
<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$80
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,580

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-367-3636.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

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

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),

1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705),

Email: CRCoordinator@aetna.com.

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 (Aetna).

Language Assistance:

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-800-367-3636.
Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-800-367-3636 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-367-3636
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-800-367-3636 առանց գնով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-367-3636 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-800-367-3636 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-800-367-3636-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-367-3636 nga walay bayad.
Burmese -	ငွေကုန်ကျခံရမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-800-367-3636 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-800-367-3636.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-800-367-3636 sin gåstu.
Cherokee -	ᎠᏍᏅᏄ ᏚᏐᏃᏗᏍᏔᏂᏲ ᏪᎡᏐᏍᏆᏍᏔᏂᏲ ᎠᏕᏓᏑ (GWY) ᎠᏂᏐᏍᏆᏍᏔᏂᏲ 1-800-367-3636 ᎠᏕᏓᏑ Ꮩ ᎠᏕᏓᏑ ᎠᏕᏓᏑ ᎠᏕᏓᏑ.
Chinese -	欲取得繁體中文語言協助，請撥打1-800-367-3636，無需付費。
Choctaw -	(Chahta) anumpa ya apela a chi I paya hinla 1-800-367-3636.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-800-367-3636 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-367-3636.
French -	Pour une assistance linguistique en français appeler le 1-800-367-3636 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-367-3636 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-367-3636 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-367-3636 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-800-367-3636 પર કોલ કરો.

Hawaiian -	No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-800-367-3636. Kāki ‘ole ‘ia kēia kōkua nei.
Hindi -	हनिदी में भाषा सहायता के लिए, 1-800-367-3636 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-367-3636.
Ibo -	Maka enyemaka asụsụ na Igbo kpọọ 1-800-367-3636 na akwughị ugwo o bula
Ilocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-367-3636 nga awan ti bayadanyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-367-3636.
Japanese -	日本語で援助をご希望の方は、1-800-367-3636 まで無料でお電話ください。
Karen -	လၢတၢ်မၤစၢၤတၢ်ကတိၣ်ကျိၣ်အီၣ် ကျိၣ် နီး 1-800-367-3636 လၢတၢ်အိၣ်ဒီးတၢ်လၢာ်သ့ၣ်လၢာ်စုၤသ့ၣ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862번으로 전화해 주십시오.
Kru-Bassa -	Bɛ́m`ké gbo-kpá-kpá dyé pidyi dé Bǎswó-wuḍuiŋ wěɛ, dá 1-800-367-3636
Kurdish -	برای راهنمایی به زبان فارسی با شماره 1-800-367-3636 به خۆرای یه‌یو مەندی بکەن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-800-367-3636 ໂດຍບໍ່ເສຍຄ່າໄທ.
Marathi -	तीलभाषा (मराठी) सहाय्यासाठी 1-800-367-3636 क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.
Marshallese -	N̄an bōk jipañ ilo Kajin Majol, kallok 1-800-367-3636 ilo ejjelok wōnān.
Micronesian-Pohnpeyan -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-367-3636 ni sohte isais.
Mon-Khmer, Cambodian -	សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-800-367-3636 ដោយឥតគិតថ្លៃ។
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-800-367-3636
Nepali -	(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1- 800-367-3636 मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tèn kuwoɲy ë thok ë Thuonjäng col 1-800-367-3636 kecîn ayöc.
Norwegian -	For språkassistanse på norsk, ring 1-800-367-3636 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-367-3636 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Hilfe in Deitsch, ruf: 1-800-367-3636 aa. Es Aaruf koschtet nix.
Persian -	برای راهنمایی به زبان فارسی با شماره 1-800-367-3636 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-367-3636.

