aetna™ Aetna Choice® POS II - TRS-ActiveCare 2

Coverage for: Individual + Family | Plan Type: POS

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.trsactivecareaetna.com or call 1-800-222-9205. 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 1-800-222-9205 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For each Plan Year, In-Network: Individual $1,000 / Family $3,000. Out-of-Network: Individual $2,000 / Family $6,000.	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.
Are there services covered before you meet your deductible?	Yes. Prescription drugs; plus in-network office visits, urgent care visits & preventive care are covered before you meet your deductible.	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 www.trsactivecareaetna.com
Are there other deductibles for specific services?	Yes. $200 for prescription drug expenses. Doesn't apply to generic drugs. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-Network: Individual $7,900 / Family $15,800. Out-of-Network: Individual $23,700 / Family $47,400.	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, bariatric surgery copays, health care this plan doesn't cover & penalties for failure to obtain pre-authorization for services.	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 www.trsactivecareaetna.com or call 1-800-222-9205 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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit, deductible doesn't apply; except 20% coinsurance for office surgery	40% coinsurance	Includes Internist, General Physician, Family Practitioner, Pediatrician or Gynecologist.
If you visit a health care provider's office or clinic	Specialist visit	$70 copay/visit, deductible doesn't apply: except 20% coinsurance for office surgery	40% coinsurance	None
If you visit a health care provider's office or clinic	Preventive care /screening /immunization	No charge, except $70 copay/visit, deductible doesn't apply, for hearing or eye exam	40% coinsurance	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.
If you have a TRS Virtual Health visit	TRS Virtual Health video/phone consult	No charge	NA	
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
If you have a test	Imaging (CT/PET scans, MRIs)	20% coinsurance after $100 copay/visit	40% coinsurance after $100 copay/visit	Pre-authorization may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition Prescription drug coverage is administered by CVS/Caremark More information about prescription drug coverage is available at www.cvscaremark.com	Generic drugs	Copay/prescription, deductible doesn't apply: $20 (Retail first fill), $35 (Retail refill), $45 (Mail Order or Retail-Plus)	Copay/prescription, deductible doesn't apply: $20 (Retail first fill), $35 (Retail refill), $45 (Mail Order or Retail-Plus)	Covers 31-day supply (Retail), 60-90 day supply (Mail Order & Retail-Plus). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in-network. Precertification & step therapy required. Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written. Out-of-Network: reimbursement is the allowed amount for what would have been charged by a network pharmacy less the copay after the drug deductible is met.
If you need drugs to treat your illness or condition Prescription drug coverage is administered by CVS/Caremark More information about prescription drug coverage is available at www.cvscaremark.com	Preferred brand drugs	Copay/prescription: 25% coinsurance, after specific deductible: minimum $40/maximum $80 (Retail first fill), minimum $60/maximum $120 (Retail refill), minimum $105/maximum $210 (Mail Order or Retail-Plus)	Copay/prescription: 25% coinsurance, after specific deductible: minimum $40/maximum $80 (Retail first fill), minimum $60/maximum $120 (Retail refill), minimum $105/maximum $210 (Mail Order or Retail-Plus)	Covers 31-day supply (Retail), 60-90 day supply (Mail Order & Retail-Plus). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in-network. Precertification & step therapy required. Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written. Out-of-Network: reimbursement is the allowed amount for what would have been charged by a network pharmacy less the copay after the drug deductible is met.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition Prescription drug coverage is administered by CVS/Caremark More information about prescription drug coverage is available at www.cvscaremark.com	Non-preferred brand drugs	Copay/prescription: 50% coinsurance, after specific deductible: minimum $100/maximum $200 (Retail first fill), minimum $105/maximum $210 (Retail refill), minimum $215/maximum $430(Mail Order or Retail-Plus)	Copay/prescription: 50% coinsurance, after specific deductible: minimum $100/maximum $200 (Retail first fill), minimum $105/maximum $210 (Retail refill), minimum $215/maximum $430(Mail Order or Retail-Plus)	Covers 31-day supply (Retail), 60-90 day supply (Mail Order & Retail-Plus). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in-network. Precertification & step therapy required. Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written. Out-of-Network: reimbursement is the allowed amount for what would have been charged by a network pharmacy less the copay after the drug deductible is met.
If you need drugs to treat your illness or condition Prescription drug coverage is administered by CVS/Caremark More information about prescription drug coverage is available at www.cvscaremark.com	Specialty drugs	20% coinsurance after specific deductible, minimum $200/maximum $900	20% coinsurance after specific deductible, minimum $200/maximum $900	All Specialty drugs must be filled at Specialty Pharmacy. Retail not covered. 31-day supply limit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after $150 copay/visit	40% coinsurance after $150 copay/visit	None
If you have outpatient surgery	Physician/surgeon fees	20% coinsurance	40% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care (hospital affiliated facility) Emergency room care (freestanding facility)	20% coinsurance: $250 copay/visit $500 copay/visit	20% coinsurance: $250 copay/visit $500 copay/visit	40% coinsurance for non-emergency use out-of-network.
If you need immediate medical attention	Emergency medical transportation	20% coinsurance	20% coinsurance	Non-emergency transport: not covered, except if pre-authorized.
If you need immediate medical attention	Urgent care	$50 copay/visit, deductible doesn't apply	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after $150 copay/day first 5 days	40% coinsurance; Member pays the balance of charge in excess of $500 per day after deductible	Maximum/plan year per individual, in network facility copay: $2,250. Penalty of $250 for failure to obtain pre-authorization for out-of-network care.
If you have a hospital stay	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient visits: $70 copay/visit, deductible doesn't apply	Office & other outpatient visits: 40% coinsurance	Pre-authorization may be required for care.
If you need mental health, behavioral health, or substance abuse services	TRS Virtual Health video consult	$70 copay/visit, deductible doesn't apply	NA	Consults can be with a psychiatrist, psychologist, licensed clinical social worker, counselor or therapist
If you need mental health, behavioral health, or substance abuse services	Inpatient services	20% coinsurance after $150 copay/day first 5 days	40% coinsurance; Member pays the balance of charge in excess of $500 per day after deductible	Maximum/plan year per individual, in network facility copay: $2,250. Penalty of $250 for failure to obtain pre-authorization for out-of-network care.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge	40% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
If you are pregnant	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
If you are pregnant	Childbirth/delivery facility services	20% coinsurance after $150 copay/day first 5 days	40% coinsurance; Member pays the balance of charge in excess of $500 per day after deductible	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Maximum facility copay/plan year per individual: $2,250. Penalty of $250 for failure to obtain pre-authorization for out-of-network care may apply.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	60 visits/plan year. Pre-authorization may be required for out-of-network care.
If you need help recovering or have other special health needs	Rehabilitation services	$70 copay/visit, deductible doesn't apply	40% coinsurance	None
If you need help recovering or have other special health needs	Habilitation services	$70 copay/visit, deductible doesn't apply	40% coinsurance	Limited to treatment of autism and to speech therapy for developmental delay.
If you need help recovering or have other special health needs	Skilled nursing care	20% coinsurance	40% coinsurance	25 days/plan year. Penalty of $250 for failure to obtain pre-authorization for out-of-network care.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Durable medical equipment	20% coinsurance	40% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
If you need help recovering or have other special health needs	Hospice services	20% coinsurance	40% coinsurance	Penalty of $250 for failure to obtain pre-authorization for out-of-network care may apply.
If your child needs dental or eye care	Children's eye exam	$70 copay/visit, deductible doesn't apply	40% coinsurance	1 routine eye exam/plan year if performed by an ophthalmologist or optometrist.
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
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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 - Limited to Institutes of Quality facility for in-network only. $5000 copay.
- Chiropractic care - 35 visits/plan year.
- Hearing aids - $1,000 maximum/36 months.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Routine eye care (Adult) - 1 routine eye exam/plan 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 1-800-222-9205.

- 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 : https://www.dol.gov/agencies/ebsa
- 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 1-800-222-9205.

- 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 https://www.dol.gov/agencies/ebsa
- 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 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	$1,000
Specialist copayment	$70
Hospital (facility) coinsurance	20%
Other coinsurance	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:	
Cost Sharing	
Deductibles*	$1,000
Copayments	$100
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,460

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

The plan's overall deductible	$1,000
Specialist copayment	$70
Hospital (facility) coinsurance	20%
Other coinsurance	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:	
Cost Sharing	
Deductibles*	$300
Copayments	$1,900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$2,220

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

The plan's overall deductible	$1,000
Specialist copayment	$70
Hospital (facility) coinsurance	20%
Other coinsurance	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:	
Cost Sharing	
Deductibles*	$1,000
Copayments	$300
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,370

Note: If your plan has a wellness program and you choose to participate, you may be able to reduce your costs.

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-222-9205.

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).

TTY: 711

Language Assistance:

For language assistance in your language call 1-800-222-9205 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-800-222-9205.
Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-800-222-9205 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-222-9205
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-800-222-9205 առանց զնով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-222-9205 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-800-222-9205 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামুল্যে 1-800-222-9205-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-222-9205 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-800-222-9205 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-800-222-9205.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-800-222-9205 sin gåstu.
Cherokee -	ᎾᏍᎩᎾ ᎦᏬᏂᎯᏍᏗ ᏗᏂᏍᏕᎵᏍᎩ ᎾᏕᎢ (ᏣᎳᎩ) ᏫᏏᎳᏛᎢᎦ 1-800-222-9205 ᎤᎾᎢ Ꮭ ᎠᎱᏍᏗ ᏧᎬᏩᎶᏗ ᏂᎨᏒᎾ.
Chinese -	欲取得繁體中文語言協助，請撥打 1-800-222-9205，無需付費。
Choctaw -	(Chahta) anumpa ya apela a chi I paya hinla 1-800-222-9205.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-800-222-9205 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-222-9205.
French -	Pour une assistance linguistique en français appeler le 1-800-222-9205 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-222-9205 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-222-9205 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-222-9205 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-800-222-9205 પર કૉલ કરો.

Hawaiian -	No ke kōkua ma ka ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-800-222-9205. Kāki ʻole ʻia kēia kōkua nei.
Hindi -	हिन्दी में भाषा सहायता के लिए, 1-800-222-9205 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-222-9205.
Ibo -	Maka enyemaka asụsụ na Igbo kpọọ 1-800-222-9205 na akwụghị ụgwọ ọ bụla
Ilocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-222-9205 nga awan ti bayadanyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-222-9205.
Japanese -	日本語で援助をご希望の方は、1-800-222-9205 まで無料でお電話ください。
Karen -	လာတ်မၤစၢၤတ်ကတိၤကျိာ်အဂီၢ် ကျိာ် ကိး 1-800-222-9205 လၢတအိဉ်ဒီးတ်လၢာ်ဘျာ်လၢာ်စုၤဘဉ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-222-9205 번으로 전화해 주십시오.
Kru-Bassa -	Bɛ´m`ké gbo-kpá-kpá dyé pídyi ɖé Bǎsɔ́ɔ̀-wùɖùǔn wɛ̃ɛ, ɖá 1-800-222-9205
Kurdish -	برای راهنمایی به زبان فارسی با شماره 1-800-222-9205 به خۆرایی یەیوەندی بکەن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ1-800-222-9205 ໂດຍບໍ່ເສຍຄ່າໃຫ.
Marathi -	तीलभाषा (मराठी) सहाय्यासाठी 1-800-222-9205 क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-222-9205 ilo ejjelok wōnān.
Micronesian-Pohnpeyan -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-222-9205 ni sohte isais.
Mon-Khmer, Cambodian -	សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-800-222-9205 ដោយឥតគិតថ្លៃ។
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-800-222-9205
Nepali -	(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-800-222-9205 मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-800-222-9205 kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-800-222-9205 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-222-9205 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-800-222-9205 aa. Es Aaruf koschtet nix.
Persian -	برای راهنمایی به زبان فارسی با شماره 1-800-222-9205 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-222-9205.

Portuguese -	Para obter assistência linguística em português ligue para o 1-800-222-9205 gratuitamente.
Romanian -	Pentru asistenţă lingvistică în româneşte telefonaţi la numărul gratuit 1-800-222-9205
Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-222-9205.
Samoan -	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-800-222-9205 e aunoa ma se totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-222-9205.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-800-222-9205.
Sudanic-Fulfude -	Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-800-222-9205. Njodi woo fawaaki on.
Swahili -	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-222-9205 bila malipo.
Syriac -	[illegible] 1-800-222-9205 [illegible].
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-222-9205 nang walang bayad.
Telugu -	భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-800-222-9205 కు కాల్ చేయండి. (తెలుగు)
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-800-222-9205 ฟรีไม่มีค่าใช้จ่าย
Tongan -	Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-800-222-9205 ‘o ‘ikai hā ōtōngi.
Trukese -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-800-222-9205 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-800-222-9205.
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-222-9205.
Urdu -	اردو میں لسانی معاونت کے لیے 1-800-222-9205 پر مفت کال کریں
Vietnamese -	Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-800-222-9205.
Yiddish -	פאר שפראך הילף אין אידיש רופט 1-800-222-9205 פריי פון אפצאל.
Yoruba -	Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-800-222-9205 lái san owó kankan rárá.