



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.tractivecareetna.com](http://www.tractivecareetna.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 <u>deductible</u> ?                             | For each <u>Plan</u> Year, Kelsey Select: Individual \$1,200 / Family \$3,600.  | 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 <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .   |
| Are there services covered before you meet your <u>deductible</u> ? | Yes. <u>Prescription drugs</u> ; plus in- <u>network</u> office visits, <u>urgent care</u> visits & <u>preventive care</u> are 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 <a href="http://www.tractivecareetna.com">www.tractivecareetna.com</a> |
| Are there other <u>deductibles</u> for specific services?           | Yes. \$200 for <u>prescription drugs</u> expenses. Doesn't apply to generic drugs. There are no other specific <u>deductibles</u> .   | You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.  |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?       | Kelsey Select: Individual \$7,900 / Family \$15,800.  | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.   |
| What is not included in the <u>out-of-pocket limit</u> ?            | <u>Premiums</u> , <u>balance-billing</u> charges & health care this <u>plan</u> doesn't cover & penalties for failure to obtain pre-authorization 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 <a href="http://www.tractivecareetna.com">www.tractivecareetna.com</a> or call 1-800-222-9205 for a list of Kelsey Select <u>providers</u> .                           | This <u>plan</u> uses a <u>provider network</u> . There is no coverage out-of-network except for true medical emergency care. If you seek care outside of the network you will be responsible for the cost. 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> ?          | Yes.  | This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</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  |
|---|---|---|---|---|
|   |   | Kelsey Care<br>(You will pay the least)   | Out-of-Network<br>Provider<br>(You will pay the most) |   |
| If you visit a health care <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness        | \$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply; except 20% <u>coinsurance</u> for office surgery | Not covered   | Includes Internist, General Physician, Family Practitioner, Pediatrician or Gynecologist.   |
| If you visit a health care <u>provider's</u> office or clinic | <u>Specialist</u> visit                                 | \$70 <u>copay</u> /visit, <u>deductible</u> doesn't apply; except 20% <u>coinsurance</u> for office surgery | Not covered   | None  |
| If you visit a health care <u>provider's</u> office or clinic | <u>Preventive care</u> / <u>screening</u> /immunization | No charge, except \$70 <u>copay</u> /visit for hearing or eye exam  | Not covered   | 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 TRS Virtual Health visit                        | TRS Virtual Health video/phone consult                  | No charge   | Not covered   |   |
| If you have a test  | <u>Diagnostic test</u> (x-ray, blood work)              | 20% <u>coinsurance</u> , except 100% at a Kelsey laboratory   | Not covered   | None  |
| If you have a test  | Imaging (CT/PET scans, MRIs)                            | 20% <u>coinsurance</u> after \$100 <u>copay</u> /visit  | Not covered   | <u>Pre-authorization</u> may be required.   |

| Common Medical Event  | Services You May Need | What You Will Pay   |   | Limitations, Exceptions, & Other Important Information  |
|---|-----------------------|---|---|---|
|   |                       | Kelsey Care<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most)  |   |
| <p>If you need drugs to treat your illness or condition</p> <p><u>Prescription drug coverage</u> is administered by CVS/Caremark</p> <p>More information about <u>prescription drug coverage</u> is available at <a href="http://www.cvscaremark.com">www.cvscaremark.com</a></p> | Generic drugs         | <p><u>Copay/prescription, deductible</u> doesn't apply: \$15 (Retail first fill), \$30 (Retail refill), \$45 (Mail Order or Retail-Plus)</p>  | <p><u>Copay/prescription, deductible</u> doesn't apply: \$15 (Retail first fill), \$30 (Retail refill), \$45 (Mail Order or Retail-Plus)</p>  | <p>Covers 31-day supply (Retail), 60-90 day supply (Mail Order or Retail-Plus). Includes contraceptive drugs &amp; devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in-<u>network</u>. Precertification &amp; step therapy are required. Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written. Out-of-Network: reimbursement is the <u>allowed amount</u> of what would have been charged by a <u>network</u> pharmacy less the <u>copay</u> after the drug <u>deductible</u> is met.</p>                       |
| <p>If you need drugs to treat your illness or condition</p> <p><u>Prescription drug coverage</u> is administered by CVS/Caremark</p> <p>More information about <u>prescription drug coverage</u> is available at <a href="http://www.cvscaremark.com">www.cvscaremark.com</a></p> | Preferred brand drugs | <p><u>Copay/prescription, after specific deductible</u>: 25% <u>coinsurance</u>: minimum \$40/maximum \$80 (Retail first fill), minimum \$60/maximum \$120 (Retail refill), minimum \$105/maximum \$210 (Mail Order or Retail-Plus)</p> | <p><u>Copay/prescription, after specific deductible</u>: 25% <u>coinsurance</u>: minimum \$40/maximum \$80 (Retail first fill), minimum \$60/maximum \$120 (Retail refill), minimum \$105/maximum \$210 (Mail Order or Retail-Plus)</p> | <p>Covers 31-day supply (Retail), 60-90 day supply (Mail Order or Retail-Plus). Includes contraceptive drugs &amp; devices obtainable from a pharmacy, oral fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-<u>network</u>. Precertification &amp; step therapy are required. Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written. Out-of-Network: reimbursement is the <u>allowed amount</u> of what would have been charged by a <u>network</u> pharmacy less the <u>copay</u> after the drug <u>deductible</u> is met.</p> |

| Common Medical Event   | Services You May Need                          | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information   |
|--|--|--|--|--|
|  |  | Kelsey Care<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most)   |  |
| <p>If you need drugs to treat your illness or condition <u>Prescription drug coverage</u> is administered by CVS/Caremark</p> <p>More information about <u>prescription drug coverage</u> is available at <a href="http://www.cvscaremark.com">www.cvscaremark.com</a></p> | Non-preferred brand drugs                      | 50% <u>coinsurance</u> , after specific <u>deductible</u> (Retail first fill/refill & Mail Order or Retail-Plus) | 50% <u>coinsurance</u> , after specific <u>deductible</u> (Retail first fill/refill & 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 fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in- <u>network</u> . Precertification & step therapy are required. Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written. Out-of-Network: reimbursement is the <u>allowed amount</u> of what would have been charged by a <u>network</u> pharmacy less the <u>copay</u> after the drug <u>deductible</u> is met. |
| <p>If you need drugs to treat your illness or condition <u>Prescription drug coverage</u> is administered by CVS/Caremark</p> <p>More information about <u>prescription drug coverage</u> is available at <a href="http://www.cvscaremark.com">www.cvscaremark.com</a></p> | <u>Specialty drugs</u>                         | 20% <u>coinsurance</u> , after specific <u>deductible</u>  | 20% <u>coinsurance</u> , after specific <u>deductible</u>  | All <u>specialty drugs</u> 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% <u>coinsurance</u> after \$150 <u>copay</u> /visit   | Not covered  | None   |
| If you have outpatient surgery   | Physician/surgeon fees                         | 20% <u>coinsurance</u>   | Not covered  | None   |

| Common Medical Event  | Services You May Need   | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information   |
|---|---|---|--|--|
|   |   | Kelsey Care<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most)                                 |  |
| If you need immediate medical attention                                   | <u>Emergency room care (hospital affiliated facility)</u><br><u>Emergency room care (freestanding facility)</u> | 20% <u>coinsurance</u> :<br>\$250 <u>copay</u> /visit<br>\$500 <u>copay</u> /visit                | 20% <u>coinsurance</u> :<br>\$250 <u>copay</u> /visit<br>\$500 <u>copay</u> /visit | None   |
| If you need immediate medical attention                                   | <u>Emergency medical transportation</u>   | 20% <u>coinsurance</u>  | 20% <u>coinsurance</u>   | Non-emergency transport: not covered, except if pre-authorized.  |
| If you need immediate medical attention                                   | <u>Urgent care</u>  | \$50 <u>copay</u> /visit,<br><u>deductible</u> doesn't apply                                      | Not covered  | None   |
| If you have a hospital stay   | Facility fee (e.g., hospital room)  | 20% <u>coinsurance</u> after<br>\$150 <u>copay</u> /day first 5 days                              | Not covered  | Maximum/ <u>plan</u> year per individual, facility copay: \$2,250.   |
| If you have a hospital stay   | Physician/surgeon fees  | 20% <u>coinsurance</u>  | Not covered  | None   |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services   | Office & other outpatient visits:<br>\$70 <u>copay</u> /visit,<br><u>deductible</u> doesn't apply | Not covered  | <u>Pre-authorization</u> may be required for care.   |
| If you need mental health, behavioral health, or substance abuse services | TRS Virtual Health video consult  | \$70 <u>copay</u> /visit,<br><u>deductible</u> doesn't apply                                      | Not covered  | 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% <u>coinsurance</u> after<br>\$150 <u>copay</u> /day first 5 days                              | Not covered  | Maximum/ <u>plan</u> year per individual, facility copay: \$2,250.   |

| Common Medical Event   | Services You May Need                     | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information   |
|--|---|---|--|--|
|  |   | Kelsey Care<br>(You will pay the least)                           | Out-of-Network Provider<br>(You will pay the most) |  |
| If you are pregnant  | Office visits                             | No charge   | Not covered  | <u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)  |
| If you are pregnant  | Childbirth/delivery professional services | 20% <u>coinsurance</u>  | Not covered  | <u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)  |
| If you are pregnant  | Childbirth/delivery facility services     | 20% <u>coinsurance</u> after \$150 <u>copay</u> /day first 5 days | Not covered  | <u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Max facility <u>copay/plan</u> year per individual: \$2,250. |
| If you need help recovering or have other special health needs | <u>Home health care</u>                   | 20% <u>coinsurance</u>  | Not covered  | 60 visits/ <u>plan</u> year.   |
| If you need help recovering or have other special health needs | <u>Rehabilitation services</u>            | \$70 <u>copay</u> /visit, <u>deductible</u> doesn't apply         | Not covered  | None   |
| If you need help recovering or have other special health needs | <u>Habilitation services</u>              | \$70 <u>copay</u> /visit, <u>deductible</u> doesn't apply         | Not covered  | Limited to treatment of autism and to speech therapy for developmental delay.  |

| Common Medical Event   | Services You May Need            | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information   |
|--|----------------------------------|---|--|--|
|  |                                  | Kelsey Care<br>(You will pay the least)                   | Out-of-Network Provider<br>(You will pay the most) |  |
| If you need help recovering or have other special health needs | <u>Skilled nursing care</u>      | 20% <u>coinsurance</u>                                    | Not covered  | 25 days/ <u>plan</u> year.   |
| If you need help recovering or have other special health needs | <u>Durable medical equipment</u> | 20% <u>coinsurance</u>                                    | Not covered  | Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse. |
| If you need help recovering or have other special health needs | <u>Hospice services</u>          | 20% <u>coinsurance</u>                                    | Not covered  | None   |
| If your child needs dental or eye care                         | Children's eye exam              | \$70 <u>copay</u> /visit, <u>deductible</u> doesn't apply | Not covered  | 1 routine eye exam/ <u>plan</u> 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
- Bariatric surgery
- 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.)



- 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](http://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](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 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](http://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 <u>plan's</u> overall <u>deductible</u> | \$1,200 |
| ■ <u>Specialist copayment</u>                 | \$70    |
| ■ Hospital (facility) <u>coinsurance</u>      | 20%     |
| ■ Other <u>coinsurance</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: |          |
| Cost Sharing                    |          |
| Deductibles*                    | \$1,200  |
| Copayments                      | \$100    |
| Coinsurance                     | \$2,200  |
| What isn't covered              |          |
| Limits or exclusions            | \$60     |
| The total Peg would pay is      | \$3,560  |

**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> | \$1,200 |
| ■ <u>Specialist copayment</u>                 | \$70    |
| ■ Hospital (facility) <u>coinsurance</u>      | 20%     |
| ■ Other <u>coinsurance</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: |         |
| Cost Sharing                    |         |
| Deductibles*                    | \$300   |
| Copayments                      | \$1,800 |
| Coinsurance                     | \$0     |
| What isn't covered              |         |
| Limits or exclusions            | \$20    |
| The total Joe would pay is      | \$2,120 |

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

|   |         |
|---|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$1,200 |
| ■ <u>Specialist copayment</u>                 | \$70    |
| ■ Hospital (facility) <u>coinsurance</u>      | 20%     |
| ■ Other <u>coinsurance</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: |         |
| Cost Sharing                    |         |
| Deductibles*                    | \$1,200 |
| Copayments                      | \$300   |
| Coinsurance                     | \$30    |
| What isn't covered              |         |
| Limits or exclusions            | \$0     |
| The total Mia would pay is      | \$1,530 |

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](mailto: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).

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Language Assistance:

|                    |  |
|--------------------|--|
| 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 -           | 1-800-222-9205 للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني   |
| Armenian -         | Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-800-222-9205 առանց գնով:  |
| 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 numero 1-800-222-9205 ku busa                                      |
| Bengali-Bangala -  | বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 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), ágang 1-800-222-9205 sin gåstu.   |
| Cherokee -         | ᏅᏍᏔᏍᏔ ᏌᏍᏈᏍᏔᏍᏔ ᏍᏈᏍᏔᏍᏔ ᏍᏈᏍᏔ (GWY) ᏍᏈᏍᏔᏍᏔ 1-800-222-9205 ᏍᏈᏍᏔ ᏍᏈᏍᏔ ᏍᏈᏍᏔ ᏍᏈᏍᏔ.   |
| 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 l 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 કોલ કરો.  |



