Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services City of Rocky Mount: Aetna Choice® POS II-HealthMapRx Consumer Driven HSA

Coverage for: EE Only; EE+ 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, www.HealthReformPlanSBC.com 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/ or call 1-800-370-4526 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|---|
| What is the overall <u>deductible</u> ? | For each <u>Plan</u> Year, In- <u>Network</u> : EE Only \$1,500; EE+ Family \$3,000. Out-of-Network: EE Only \$3,000; EE+ Family \$6,000. | 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- <u>network 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 <u>https://www.healthcare.gov/coverage/preventive-care-benefits/</u> |
| Are there other <u>deductible</u> s for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ? | In- <u>Network</u> : EE Only \$3,500; EE+ Family \$5,000. Out-of-Network: EE Only \$7,000; EE+ Family \$10,000. | 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> , the overall family <u>out–of–pocket limit</u> must be met. |
| What is not included in the out-of-pocket limit? | Premiums, balance-billing charges, health care this <u>plan</u> doesn't cover & 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.aetna.com/docfind or call 1-800- 370-4526 for a list of <u>network providers</u> . | This <u>plan</u> uses a <u>provider</u> <u>network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's</u> <u>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 **<u>copayment</u>** and **<u>coinsurance</u>** costs shown in this chart are after your **<u>deductible</u>** has been met, if a **<u>deductible</u>** applies.

| Common Medical | Services You May Need | What You In-Network Provider | u Will Pay Out-of-Network Provider | Limitations, Exceptions, & Other Important |
|--|--|--|---|--|
| Event | | (You will pay the least) | (You will pay the most) | Information |
| | Primary care visit to treat an injury or illness | 20% coinsurance | 50% coinsurance | None |
| If you visit a health | <u>Specialist</u> visit | 20% coinsurance | 50% coinsurance | None |
| care <u>provider</u> 's office or clinic | Preventive care /screening /immunization | No charge | 50% <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 | Diagnostic test (x-ray, blood work) | 20% coinsurance | 50% coinsurance | None |
| If you have a test | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 50% coinsurance | Prior Authorization required. |
| If you need drugs to treat your | Generic drugs | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> after <u>copay</u> / prescription: 20% (retail) | Covers 30 day supply (retail), 31-90 day supply (retail & participating mail order). Includes |
| illness or condition More information | Preferred brand drugs | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> after <u>copay</u> / prescription: 20% (retail) | contraceptive drugs & devices obtainable from a pharmacy, oral fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in- <u>network</u> . Your cost will be |
| about <u>prescription</u> <u>drug coverage</u> is available at www.aetnapharmac y.com/standard | Non-preferred brand drugs | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> after <u>copay</u> / prescription: 20% (retail) | higher for choosing Brand over Generics unless prescribed Dispense as Written. <u>Deductible</u> doesn't apply to certain preventive medications. |
| y.com/standard | Specialty drugs | Applicable cost as noted above for generic or brand drugs | Not covered | First prescription fill at a retail pharmacy or specialty pharmacy. Subsequent fills must be through the Aetna Specialty Pharmacy <u>Network</u> . Precertification required for coverage. |
| If you have | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 50% coinsurance | None |
| outpatient surgery | Physician/surgeon fees | 20% coinsurance | 50% <u>coinsurance</u> | None |
| If you need | Emergency room care | 20% coinsurance | 20% coinsurance | No coverage for non-emergency use. |
| immediate medical attention | Emergency medical transportation | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | Non-emergency transport: not covered, except if pre-authorized. |

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| | | What You | u Will Pay | |
|--|---|--|--|---|
| Common Medical Event | Services You May Need | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
| | <u>Urgent care</u> | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | Penalty of \$400 for failure to obtain <u>pre-</u> <u>authorization</u> for out-of-network care. |
| nospital stay | Physician/surgeon fees | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | None |
| If you need mental health, behavioral health, or | Outpatient services | Office & other outpatient services: 20% <u>coinsurance</u> | Office & other outpatient services: 50% <u>coinsurance</u> | None |
| substance abuse services | Inpatient services | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | Penalty of \$400 for failure to obtain <u>pre-</u> <u>authorization</u> for out-of-network care. |
| | Office visits | No charge | 50% coinsurance | Cost sharing does not apply for preventive |
| | Childbirth/delivery professional services | 20% <u>coinsurance</u> | 50% coinsurance | services. Maternity care may include tests and |
| lf you are pregnant | Childbirth/delivery facility services | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | 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. |
| | Home health care | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | Penalty of \$400 for failure to obtain <u>pre-</u> authorization for out-of-network care. |
| <i>и</i> 11 1 | Rehabilitation services | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | 30 visits/ <u>plan</u> year for Physical, Occupational Therapy & Chiropractic care combined, 30 visits/ <u>plan</u> year for Speech Therapy. |
| If you need help recovering or have | Habilitation services | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | None |
| other special health needs | Skilled nursing care | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | 60 days/ <u>plan</u> year. Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care. |
| nealth needs | Durable medical equipment | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse. |
| | Hospice services | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | Penalty of \$400 for failure to obtain <u>pre-</u> <u>authorization</u> for out-of-network care. |
| If your obild poods | Children's eye exam | No charge | 50% <u>coinsurance</u> | 1 routine eye exam/ <u>plan</u> year. |
| If your child needs dental or eye care | Children's glasses | Not covered | Not covered | Not covered. |
| | Children's dental check-up | Not covered | Not covered | Not covered. |

Excluded Services & Other Covered Services:

| Acupuncture | Glasses (Child) | Non-emergency care when traveling outside the U.S. |
|---|---|--|
| Cosmetic surgery | Hearing aids | Routine foot care |
| Dental care (Adult & Child) | Long-term care | Weight loss programs - Except for required preventive |
| | | services. |
| | | |
| ther Covered Services (Limitations may a | pply to these services. This isn't a comp | lete list. Please see your <u>plan</u> document.) |
| ther Covered Services (Limitations may a Bariatric surgery | pply to these services. This isn't a comp Infertility treatment - Limited to t | |
| Other Covered Services (Limitations may a Bariatric surgery Chiropractic care - 30 visits/<u>plan</u> year | | he diagnosis • Routine eye care (Adult) - 1 routine eye exam/ <u>plan</u> 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 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/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 <u>www.cciio.cms.gov</u>.
- If your coverage is a church <u>plan</u>, church <u>plans</u> 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 <u>Health Insurance</u> <u>Marketplace</u>. For more information about the <u>Marketplace</u>, visit <u>www.HealthCare.gov</u> or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. 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 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/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 <u>appeal</u>. Contact information is at: <u>http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html</u>.

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 <u>plan</u> 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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 |
|---|---------|
| Specialist coinsurance | 20% |
| Hospital (facility) <u>coinsurance</u> | 20% |
| Other <u>coinsurance</u> | 20% |

This EXAMPLE event includes services like:Specialistoffice visits (prenatal care)Childbirth/DeliveryProfessional ServicesChildbirth/DeliveryFacility ServicesDiagnostic tests(ultrasounds and blood work)Specialistvisit (anesthesia)

| Total Example Cost | \$12,700 |
|---------------------------------|----------|
| In this example, Peg would pay: | |
| <u>Cost Sharing</u> | |
| Deductibles | \$1,500 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$2,000 |
| 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 wellcontrolled condition)

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

This EXAMPLE event includes services like:Primary care physicianoffice visits (including
disease education)Diagnostic tests (blood work)Prescription drugsDurable medical equipment (glucose meter)

| Total Example Cost | \$5,600 |
|---------------------------------|---------|
| In this example, Joe would pay: | |
| <u>Cost Sharing</u> | |
| Deductibles | \$1,500 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$800 |
| What isn't covered | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$2,320 |

(in-network emergency room visit and follow up care)

| The <u>plan's</u> overall <u>deductible</u> | \$1,500 |
|---|---------|
| Specialist coinsurance | 20% |
| 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 | \$2,800 |
|---------------------------------|---------|
| In this example, Mia would pay: | |
| <u>Cost Sharing</u> | |
| Deductibles | \$1,500 |
| <u>Copayments</u> | \$0 |
| Coinsurance | \$300 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,800 |

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

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 866-393-0002.

Smartphone or Tablet

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

Non-Discrimination

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

We provide free aids/services to people with disabilities and to people who need language assistance.

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

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting: Civil Rights Coordinator, P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779), 1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

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TTY: 711

Language Assistance:

For language assistance in your language call 1-800-370-4526 at no cost.

| Albanian - | Për asistencë në gjuhën shqipe telefononi falas në 1-800-370-4526. |
|----------------------------------|--|
| Amharic - | ለቋንቋ እንዛ በ አማርኛ በ 1-800-370-4526 በነጻ ይደውሉ |
| Arabic - | للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 626-370-4520 |
| Armenian - | Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-800-370-4526 առանց գնով։ |
| 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 nomero 1-800-370-4526 ku busa |
| Bengali-Bangala - | বাংলায় ভাষা সহায়তার জন্য বিনামুল্যে 1-800-370-4526-তে কল করুন। |
| Bisayan-Visayan - | Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-370-4526 nga walay bayad. |
| Burmese - | ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-800-370-4526 ကို ခေါ်ဆိုပါ။ |
| Catalan - | Per rebre assistència en (català), truqui al número gratuït 1-800-370-4526. |
| Chamorro - | Para ayuda gi fino' (Chamoru), ågang 1-800-370-4526 sin gåstu. |
| Cherokee - | Օ ⅆ℣Ѳ ֍℗ℎ <i>ℬ</i> ⅆℋ <i>⅄</i> ℎⅆ⅁ℇℙⅆ℣ ϴţT (GWУ) ℗Ხℍℰ℩℁ 1-800-370-4526 ℺ϴℾ Ը ⅄ℾⅆℋ ⅆℇႺℙℋℎͰ℞ϴ. |
| 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 y <u>a</u> apela a chi I p <u>a</u> ya 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 χωوίς χρέωση. |
| Gujarati - | ગુજરાતીમાં ભાષામાં સહ્રાય માટે કોઈ પણ ખર્ચ વગર 1-800-370-4526 પર કૉલ કરો. |
| Hawaiian - Proprietary | 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 - | हनि्दी में भाषा सहायता के लएि, 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. |
| lbo - | Maka enyemaka asụsụ na Igbo kpọọ 1-800-370-4526 na akwụghị ụgwọ ọ bụla |
| llocano - | Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-370-4526 nga awan ti bayadanyo. |
| Italian - | Per ricevere assistenza linguistica in italiano, può 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 - | လ၊ တၢိမၢစားတၢိဳကတိးကျိဉ်အဂ်ီ၊ ကျိဉ် d£800-370-4526 လ၊ တအိုဉ်ဒီးတၢိဳလ၊ ၁၁၅ဉ်လ၊ ၁စူးဘဉ် |
| Korean - | 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-370-4526 번으로 전화해 주십시오. |
| Kru-Bassa - | Ɓɛ´m`ké gbo-kpá-kpá dyé pidyi dé Ɓašɔɔ́>̀wùdุùùň wɛ̃ɛ, dá 1-800-370-4526 |
| Kurdish - | بر اي ر اهنمايي به زبان فارسي با شمار ه 4526-370-1800 به خوّر ايي پهيو مندي بکهن. |
| Laotian - | ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ1-800-370-4526 ໂດຍບໍ່ເສຍຄ່າໂທ. |
| Marathi - | कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-800-370-4526 वर फोन करा. |
| Marshallese - | Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-370-4526 ilo ejjelok wōnān. |
| Micronesian- Pohnpeyan - | Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-370-4526 ni sohte isais. |
| Mon-Khmer, Cambodian - | សម្ភាប់ជំនួយភាសាជា ភាសាខ្មមរៃ សូមទូរស័ព្ទទទៅកាន់លខេ 1-800-370-4526 ដោយឥតគិតថ្លាំ។ |
| Navajo - | T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-800-370-4526 |
| Nepali - | (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-800-370-4526 मा फोन गर्नुहोस् । |
| Nilotic-Dinka - | Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-800-370-4526 kecïn aɣöc. |
| Norwegian - | For språkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt. |
| Panjabi - | ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-370-4526 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ। |
| Pennsylvania Dutch - | Fer Helfe in Deitsch, ruf: 1-800-370-4526 aa. Es Aaruf koschtet nix. |
| Persian - | برای راهنمایی به زبان فارسی با شماره 370-4526 بدون هیچ هزینه ای تماس بگیرید. انگلیسی |
| 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 |
| Proprietary | |

Proprietary

| 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 totogi. |
| Serbo-Croatian - | Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-370-4526. |
| Spanish - | Para obtener asistencia lingüística en español, llame sin cargo al 1-800-370-4526. |
| Sudanic-Fulfude - | Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 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 - | ר שבר רג א שביוו מאר שלב ד ממואיר הר לית isper זאל, שם 1-800-370-4526 משי . |
| 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 కాల్ చేయండి. (తెలుగు) |
| Thai - | สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 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 ōtōngi. |
| Trukese - | Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-800-370-4526 nge esapw kamé ngonuk. |
| Turkish - | (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-800-370-4526. |
| Ukrainian - | Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-370-4526. |
| Urdu - | بلاقیمت زیان سے متعلقہ خدمات حاصل کرنے کے لیے ، 4526-370-1800 ۔ پر بات کریں۔ |
| Vietnamese - | Đê được hố trợ ngôn ngữ băng (ngôn ngữ), hấy gọi miến phi đên số 1-800-370-4526. |
| Yiddish - | פאר שפראך הילף אין אידיש רופט 1-800-370-4526 פריי פון אפצאל. |
| Yoruba - | Fún ìrànlowo nípa èdè (Yorùbá) pe 1-800-370-4526 lái san owó kankan rárá. |