The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, https://www.aetna.com/docfind or by calling 1-877-437-6535. 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 1-877-437-6535 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>For each Plan Year, Individual $500 / Family Not Applicable.</td>
<td>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.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Prescription drugs; plus in-network preventive care are covered before you meet your deductible.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a></td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>In-Network: Individual $6,350 / Family $12,700. Out-of-Network: Individual $6,350 / Family NONE.</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges, health care this plan doesn’t cover &amp; penalties for failure to obtain pre-authorization for services.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-877-437-6535 for a list of in-network providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, https://www.aetna.com/docfind or by calling 1-877-437-6535. 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 1-877-437-6535 to request a copy.
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Specialist visit</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% coinsurance, deductible doesn't apply</td>
<td>40% coinsurance, deductible doesn't apply</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance, deductible doesn't apply</td>
<td>40% coinsurance, deductible doesn't apply</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>Copay/prescription, deductible doesn't apply: $15 (retail)</td>
<td>Copay/prescription, deductible doesn't apply: $15 (retail)</td>
</tr>
</tbody>
</table>

More information about **prescription drug coverage** is available at https://www.aetna.com/individuals-families/pharmacy.html.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay (In-Network Provider)</th>
<th>What You Will Pay (Out-of-Network Provider)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Preferred brand drugs</td>
<td>Copay/prescription, deductible doesn't apply: $30 (retail)</td>
<td>Copay/prescription, deductible doesn't apply: $30 (retail)</td>
<td>Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs &amp; devices obtainable from a pharmacy, oral fertility drugs. No charge for preferred generic FDA-approved women’s contraceptives in-network. Review your formulary for prescriptions requiring pre-certification or step therapy for coverage.</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Non-preferred brand drugs</td>
<td>Copay/prescription, deductible doesn't apply: $60 (retail)</td>
<td>Copay/prescription, deductible doesn't apply: $60 (retail)</td>
<td>Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs &amp; devices obtainable from a pharmacy, oral fertility drugs. No charge for preferred generic FDA-approved women’s contraceptives in-network. Review your formulary for prescriptions requiring pre-certification or step therapy for coverage.</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Specialty drugs</td>
<td>Copay/prescription, deductible doesn't apply: $60 (retail)</td>
<td>Copay/prescription, deductible doesn't apply: $60 (retail)</td>
<td>First prescription fill at a retail pharmacy or specialty pharmacy. Subsequent fills must be through the Aetna Specialty Pharmacy Network.</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay In-Network Provider (You will pay the least)</td>
<td>What You Will Pay Out-of-Network Provider (You will pay the most)</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>------------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>20% coinsurance after $75 copay/visit</td>
<td>20% coinsurance after $75 copay/visit</td>
<td>No coverage for non-emergency use.</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>Non-emergency transport: not covered, except if pre-authorized.</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Urgent care</td>
<td>20% coinsurance after $25 copay/visit</td>
<td>40% coinsurance after $25 copay/visit</td>
<td>No coverage for non-urgent use.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance after $100 copay/stay</td>
<td>40% coinsurance after $250 copay/stay</td>
<td>Penalty of $500 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office &amp; other outpatient services: 20% coinsurance</td>
<td>Office &amp; other outpatient services: 40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Inpatient services</td>
<td>20% coinsurance after $100 copay/stay</td>
<td>40% coinsurance after $250 copay/stay</td>
<td>Penalty of $500 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>20% coinsurance</td>
<td>Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of $500 for failure to obtain pre-authorization for out-of-network care may apply.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of $000 for failure to obtain pre-authorization for out-of-network care may apply.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
<td>--------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Childbirth/delivery facility services</td>
<td>In-Network Provider (You will pay the least): 20% coinsurance after $100 copay/stay; Out-of-Network Provider (You will pay the most): 40% coinsurance after $250 copay/stay</td>
<td>Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of $000 for failure to obtain pre-authorization for out-of-network care may apply.</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>In-Network Provider (You will pay the least): 20% coinsurance; Out-of-Network Provider (You will pay the most): 40% coinsurance</td>
<td>Penalty of $500 for failure to obtain pre-authorization for out-of-network care.</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Rehabilitation services</td>
<td>In-Network Provider (You will pay the least): 20% coinsurance; Out-of-Network Provider (You will pay the most): 40% coinsurance</td>
<td>Includes Physical, Occupational &amp; Speech Therapy.</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Habilitation services</td>
<td>In-Network Provider (You will pay the least): 20% coinsurance; Out-of-Network Provider (You will pay the most): 40% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Skilled nursing care</td>
<td>In-Network Provider (You will pay the least): 20% coinsurance after $100 copay/stay; Out-of-Network Provider (You will pay the most): 40% coinsurance after $250 copay/stay</td>
<td>100 days/plan year. Penalty of $500 for failure to obtain pre-authorization for out-of-network care.</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Durable medical equipment</td>
<td>In-Network Provider (You will pay the least): 20% coinsurance; Out-of-Network Provider (You will pay the most): 40% coinsurance</td>
<td>Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Hospice services</td>
<td>In-Network Provider (You will pay the least): 20% coinsurance; Out-of-Network Provider (You will pay the most): 40% coinsurance</td>
<td>Penalty of $500 for failure to obtain pre-authorization for out-of-network care.</td>
<td></td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>In-Network Provider (You will pay the least): No charge; Out-of-Network Provider (You will pay the most): 40% coinsurance, deductible doesn't apply</td>
<td>1 routine eye exam/plan year. Covered through the end of the month in which the covered person turns 19.</td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay In-Network Provider (You will pay the least)</td>
<td>What You Will Pay Out-of-Network Provider (You will pay the most)</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-------------------------------</td>
<td>-----------------------------------------------------------------</td>
<td>------------------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's glasses</td>
<td>No charge</td>
<td>20% coinsurance, deductible doesn't apply</td>
<td>1 pair of glasses or lenses/plan year. Covered through the end of the month in which the covered person turns 19.</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's dental check-up</td>
<td>No charge</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
</tbody>
</table>

**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.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Routine eye care (Adult)
- 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.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids - 1 hearing aid per ear/plan year.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing - 1 visit/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: Maryland Office of the Attorney General, Health Education and Advocacy Unit, (800) 492-6116, http://insurance.maryland.gov/Consumer
- For more information on your rights to continue coverage, contact the plan at 1-877-437-6535.
- State Consumer Assistance Program, if other than state insurance department contact Maryland Office of the Attorney General, Health Education and Advocacy Unit, 200 St. Paul Place, 16th Floor, Baltimore, MD 21202, (877) 261-8807, http://www.marylandattorneygeneral.gov/Pages/CPD/HEAU/default.aspx, heau@oag.state.md.us

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 1-877-437-6535.
- Additionally, a consumer assistance program can help you file your appeal. Contact Maryland Office of the Attorney General, Health Education and Advocacy Unit, 200 St. Paul Place, 16th Floor, Baltimore, MD 21202, (877) 261-8807, http://www.marylandattorneygeneral.gov/Pages/CPD/HEAU/default.aspx, heau@oag.state.md.us

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.

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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: $500
- Specialist copayment: 20%
- Hospital (facility) copayment: 20%
- Other copayment: 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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$40</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,400</td>
</tr>
</tbody>
</table>

**What isn't covered**

- Limits or exclusions: $60

**The total Peg would pay is:** $3,000

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

- The plan’s overall deductible: $500
- Specialist copayment: 20%
- Hospital (facility) copayment: 20%
- Other copayment: 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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,300</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$100</td>
</tr>
</tbody>
</table>

**What isn't covered**

- Limits or exclusions: $20

**The total Joe would pay is:** $1,920

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

- The plan’s overall deductible: $500
- Specialist copayment: 20%
- Hospital (facility) copayment: 20%
- Other copayment: 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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$300</td>
</tr>
</tbody>
</table>

**What isn't covered**

- Limits or exclusions: $0

**The total Mia would pay is:** $800

Note: These numbers assume the patient does not participate in the plan’s wellness program. If you participate in the plan’s wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-877-437-6535.
Assistive Technology
Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-877-437-6535.

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.
TTY: 711

**Language Assistance:**

For language assistance in your language call 1-877-437-6535 at no cost.

**Albanian -** Për asistencë në gjihën shqipe telefononi falas në 1-877-437-6535.

**Amharic -** እንጋጌ ከማ እን መሪና የ 1-877-437-6535 በተ የ የorraine-

**Arabic -** للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-877-437-6535

**Armenian -** Ներկայացուցչություն (հաշվի) գումար 1-877-437-6535 տեղափոխվում է.

**Bahasa Indonesia -** Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-877-437-6535 tanpa dikenakan biaya.

**Bantu-Kirundi -** Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-877-437-6535 ku busa

**Bengali-Bangala -** বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-877-437-6535-তে কল করুন।

**Bisayan-Visayan -** Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-877-437-6535 nga walay bayad.

**Burmese -** အင်္ဂါ အိမ်ထွင်းကြည့်တွင် (ပြုလုပ်ခွင့်) ကြည့်ရှိ 1-877-437-6535

**Catalan -** Per rebre assistència en (català), truqui al número gratuït 1-877-437-6535.

**Chamorro -** Para ayuda gi fino' (Chamoru), ágang 1-877-437-6535 sin gástu.

**Cherokee -** ዓለፈ ያስቀር ያስቀር ያስቀር ያስቀር ያስቀር ያስቀር ያስቀር ያስቀር ያስቀር ያስቀር ያስቀር ያስቀር ያስቀር ያስቀር ያስቀср ያስቀር ያስቀር ያስቀር ያስቀር ያስቀር ያስቀር ያስቀር ያስቀር ያስቀር ያስቀር ያስቀር ያስquerySelector (GWV) ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያስquerySelector ያstruk (EGP, I hPRO.

**Chinese -** 欲取得繁體中文語言協助，請撥打1-877-437-6535，無需付費。

**Choctaw -** (Chahta) anumpa ya apela a chi l paya hinla 1-877-437-6535.

**Cushite -** Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-877-437-6535 iratti bilisanaa bilbilaa.

**Dutch -** Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-877-437-6535.

**French -** Pour une assistance linguistique en français appelez le 1-877-437-6535 sans frais.

**French Creole -** Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-877-437-6535 gratis.

**German -** Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-877-437-6535 an.

**Greek -** Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-877-437-6535 κωντίς χρέωσην.

**Gujarati -** ગુજરાતીમાં લાભ મળે હેઠળ પર્યાપ્ત વગર 1-877-437-6535 પર કોલ કરો.

Hindi - हिन्दी में भाषा सहायता के लिए, 1-877-437-6535 पर मुफ्त कॉल करें।

Hmong - Maka enyemaka asusû na Igbo kpôô 1-877-437-6535 na akwughî ùgwo ò bula

Ibo - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-877-437-6535 nga awan ti bayadanyo.

Ilocano - Per riceverre assistenza linguistica in italiano, puo’ chiamare gratuitamente 1-877-437-6535.

Japanese - 日本語で援助をご希望の方は、1-877-437-6535 まで無料でお電話ください。

Karen - Be’m ke gbo-kpa-kpa dyê pidyi de Basoô-wuquûn wée, qá 1-877-437-6535

Kurdish - برای راهنمايی به زبانفارسی با شماره 1-877-437-6535 به حوزه‌ای پایگاهی بکن.

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-877-437-6535 번으로 전화해 주십시오.

Kru - Ñan bôk jipañ ilo Kajin Majol, kallok 1-877-437-6535 ilo ejjelok wônan.

Laotian - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-877-437-6535 ni sohte isais.

Marathi - पण तीलभाषा (मराठी) सहाय्यासाठी 1-877-437-6535 क्रमांकावरकोणत्याहीखर्ााशिवायकॉलकरा.

Marshallese - Tën kuøøny ê thok ê Thuøñjæn coû 1-877-437-6535 kecîn ayôc.

Norwegian - For språkassistanse på norsk, ring 1-877-437-6535 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਲਈ, 1-877-437-6535 ਦੀਆ ਸੁਧਿ ਵਰਸ ਵਲੇ।


Persian - برای راهنمايی به زبانفارسی با شماره 1-877-437-6535 بدون هیچ هزینه ای تماس بگیرید. انگلیسی

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-877-437-6535.
Para obter assistência linguística em português ligue para o 1-877-437-6535 gratuitamente.

Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-877-437-6535

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-877-437-6535.

Mo fesoasoani tau gagana le Gagana Samoa vala'au le 1-877-437-6535 e aunoa ma se tototi.

Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-877-437-6535.

Fii yo on hebu balal e ko yowiti e haala Pular noddee e oo numero doo 1-877-437-6535. Njodi woo fawaaki on.

Para obtener asistencia lingüística en español, llame sin cargo al 1-877-437-6535.

Ukihitaji usaidizi katika lugha ya Kiswahili pigia simu kwa 1-877-437-6535 bila malipo.

Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-877-437-6535 nang walang bayad.

భాషతో సాయం కొరకు ఎలంటి ఖరచు లేకుండా 1-877-437-6535 కు కాల్ చేయండి. (తెలుగు)

สำหรับความช่วยเหลือทางต้านภาษาเป็น ภาษาไทย โทร 1-877-437-6535 ฟรีไม่มีค่าใช้จ่าย

Kapau ‘oku fiema’u hā tokoni ‘i he lea faka-Tonga telefoni 1-877-437-6535 ‘o ‘ikai hā ʻōtōngi.

Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-877-437-6535 nge esapw kamé ngonuk.

(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-877-437-6535.

Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-877-437-6535.

اً لْكَنْتَ رَبِّي 1-877-437-6535 ـ سَيْلَكَكُمْ وَ اعْمَيْنَ لِلَّمِّ رَيْمْ وَ دُرَ

Để được hỗ trợ ngôn ngữ (ngôn ngữ), hãy gọi miễn phí đến số 1-877-437-6535.

פָּרָא שְׁפַרְאַר הָרָּחַץ אֶּזְיֵית אָדָם 1-877-437-6535

Fún ọrùnlọwọ nípa èdè (Yorùbá) pe 1-877-437-6535 lái san owó kankan rará.