Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services SCHOOL EMPLOYEES RETIREMENT SYSTEM OF OHIO: Aetna Choice® POS II - HCPII

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, 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> ?	In- <u>Network</u> : Individual \$2,000 / Family \$4,000. Out-of-Network: Individual \$4,000 / Family \$8,000.	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 <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. Emergency care; plus in- <u>network</u> office 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 <u>https://www.healthcare.gov/coverage/preventive-care-benefits/</u>
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet deductibles for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In- <u>Network</u> : Individual \$7,350 / Family \$14,700. Out-of-Network: Individual NONE / Family NONE.	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</u> <u>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>Premium</u> s, <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover, certain non-essential specialty pharmacy drugs & 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 <u>www.aetna.com</u> or call 1-800-826- 6259 for a list of in- <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's</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.

			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
	Primary care visit to treat an injury or illness	\$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply	90% <u>coinsurance</u>	None
If you visit a health care <u>provider</u> 's office or clinic	<u>Specialist</u> visit	\$25 <u>copay</u> /visit, <u>deductible</u> doesn't apply	90% <u>coinsurance</u>	None
	Preventive care /screening /immunization	No charge	90% <u>coinsurance,</u> except no charge for flu & pneumonia vaccines	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	90% <u>coinsurance</u>	None
li you nave a lest	Imaging (CT/PET scans, MRIs)	20% coinsurance	90% <u>coinsurance</u>	None
If you need drugs to treat your illness or	Generic drugs	<u>Copav</u> /prescription: \$7.50 (retail), \$15 (mail order)	Not covered	
condition <u>Prescription drug</u> <u>coverage</u> is administered by Express Scripts More information about <u>prescription</u>	Preferred brand drugs	25% <u>coinsurance</u> with minimum & maximum/ prescription: \$25 minimum & \$100 maximum (retail), \$45 minimum & \$200 maximum (mail order)	Not covered	Covers 34 day supply (retail), 35-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in- <u>network</u> . Maintenance medications must be filled at mail after the initial retail fill.
drug coverage is	Non-preferred brand drugs	Not covered	Not covered	1

Common Medical Event	Services You May Need	What You In-Network Provider (You will pay the least)	u Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
available at <u>www.express-</u> <u>scripts.com</u>	<u>Specialty drugs</u>	25% <u>coinsurance</u> with minimum & maximum/ prescription: \$25 minimum & \$100 maximum (retail); Accredo: 25% <u>coinsurance</u> of the cost up to \$67 for preferred brand. If enrolled in the SaveonSP <u>copay</u> assistance program for certain <u>specialty</u> <u>drugs</u> : no charge	Not covered	First prescription must be filled at Express Scripts' Specialty Pharmacy, Accredo. Subsequent fills must be through Express Scripts' Specialty Pharmacy, Accredo. Exceptions to this policy apply for specialty medications needed within 24 hours of a hospital stay. Call Express Scripts for more information at 1-866-685-2791. Non-essential health benefit <u>specialty drugs</u> under the SaveonSP program do not accumulate to the <u>out-of-pocket limit</u> .
If you have	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	90% <u>coinsurance</u>	None
outpatient surgery	Physician/surgeon fees	20% coinsurance	90% coinsurance	None
	Emergency room care	\$150 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$150 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . 50% <u>coinsurance</u> in- <u>network</u> & 90% <u>coinsurance</u> out-of-network for non-emergency use.
If you need immediate medical attention	Emergency medical transportation	\$150 <u>copay</u> /trip, <u>deductible</u> doesn't apply	\$150 <u>copay</u> /trip, <u>deductible</u> doesn't apply	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> .
	<u>Urgent care</u>	\$40 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$40 <u>copay</u> /visit, <u>deductible</u> doesn't apply	None
lf you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u> after \$250 <u>copay</u> /stay	90% <u>coinsurance</u> after \$290 <u>copay</u> /stay	Penalty of \$500 for failure to obtain <u>pre-</u> <u>authorization</u> for out-of-network care.
	Physician/surgeon fees	20% coinsurance	90% coinsurance	None

Common Medical Event	Services You May Need	What You In-Network Provider (You will pay the least)	u Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
lf you need mental health, behavioral health, or	Outpatient services	Office & other outpatient services: \$20 <u>copay</u> /visit, <u>deductible</u> applies	Office & other outpatient services: 90% <u>coinsurance</u>	None
substance abuse services	Inpatient services	20% <u>coinsurance</u> after \$250 <u>copay</u> /stay	90% <u>coinsurance</u> after \$290 <u>copay</u> /stay	Penalty of \$500 for failure to obtain <u>pre-</u> authorization for out-of-network care.
	Office visits	No charge	90% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive</u> services. Maternity care may include tests and
If you are pregnant	Childbirth/delivery professional services Childbirth/delivery facility services	20% <u>coinsurance</u> 20% <u>coinsurance</u> after \$250 <u>copay</u> /stay	90% <u>coinsurance</u> 90% <u>coinsurance</u> after \$290 <u>copay</u> /stay	services described elsewhere in the SBC (i.e., ultrasound). Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
	Home health care	20% <u>coinsurance</u>	90% <u>coinsurance</u>	Penalty of \$500 for failure to obtain <u>pre-</u> authorization for out-of-network care.
	Rehabilitation services	20% coinsurance	90% <u>coinsurance</u>	None
If you need help	Habilitation services	No charge	90% <u>coinsurance</u>	None
recovering or have other special health needs	Skilled nursing care	20% coinsurance	90% <u>coinsurance</u>	100 days/calendar year. Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Durable medical equipment	20% <u>coinsurance</u>	90% <u>coinsurance</u>	None
	Hospice services	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Penalty of \$500 for failure to obtain <u>pre-</u> <u>authorization</u> for out-of-network care.
	Children's eye exam	No charge	90% <u>coinsurance</u>	1 routine eye exam/calendar year.
If your child needs dental or eye care	Children's glasses	Not covered	Not covered	These expenses are available if you elect a separate vision <u>plan</u> . Contact SERS.
	Children's dental check-up	Not covered	Not covered	These expenses are available if you elect a separate <u>plan</u> . Contact SERS.

Excluded Services & Other Covered Services:

Cosmetic surgery	Hearing aids	 Non-preferred brand drugs
Dental care (Adult & Child)	Long-term care	Routine foot care
Glasses (Child)	 Non-emergency care when traveling outside the U.S. 	 Weight loss programs – except for required <u>preventiv</u> services
	nay apply to these services. This isn't a complete list. Ple	ease see your plan document.)
Other Covered Services (Limitations in		, <u>,</u> ,

Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For more information on your rights to continue coverage, contact the <u>plan</u> 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 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 plan 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:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-800-370-4526. 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>.
- 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>	\$2,000
Specialist copayment	\$25
Hospital (facility) <u>coinsurance</u>	20%
Other <u>coinsurance</u>	20%

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

Total Example Cost	\$12,700
In this example, Peg would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$10
Coinsurance	\$1,900
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,970

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>	\$2,000
Specialist copayment	\$25
Hospital (facility) <u>coinsurance</u>	20%
Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like: <u>Primary care physician</u> office visits (including disease education) <u>Diagnostic tests</u> (blood work) <u>Prescription drugs</u> <u>Diabetic supplies</u> (glucose meter)

Total Example Cost	\$5,600
In this example, Joe would pay:	
<u>Cost Sharing</u>	
Deductibles	\$2,000
<u>Copayments</u>	\$400
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$2,420

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

The plan's overall <u>deductible</u>	\$2,000
Specialist copayment	\$25
Hospital (facility) <u>coinsurance</u>	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	\$2,800
In this example, Mia would pay:	
<u>Cost Sharing</u>	
Deductibles	\$400
<u>Copayments</u>	\$400
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$800

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-370-4526.

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, disability, gender identity or sexual orientation.

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), <u>CRCoordinator@aetna.com</u>.

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:

To access language services at no cost to you, call 1-800-370-4526.

Albanian -	Për shërbime përkthimi falas për ju, telefononi 1-800-370-4526.
Amharic -	የቋንቋ አንልግሎቶችን ያለክፍያ ለማግኘት፣ በ ו-800-370-4526 ይደውሉ።
Arabic -	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء االتصال على الرقم 4526-370-1800
Armenian -	Անվձար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-800-370-4526 հեռախոսահամարով։
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.
Bantu-Kirundi -	Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-800-370-4526.
Bengali-Bangala -	আপনাকে বিনামূকযে ভাষা পবিকষিা পপকে হকয এই নম্বকি পেবযক ান েরুন: 1-800-370-4526।
Bisayan-Visayan -	Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-800-370-4526.
Burmese -	သင့္အေနျဖင့္ အခေၾကးေငြ မေပးရပဲ ဘာသာစကားဝန္ေဆာင္မႈမ်ား ရရွိႏုိင္ရန္ 1-800-370-4526 သို ^႕ ဖုန္းေခၚဆုိပါ။
Catalan -	Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-800-370-4526.
Chamorro -	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-800-370-4526.
Cherokee -	GУФЛ SOHADI OGOLONI L АГФЛ ЛGEGWЛЛ ЉУ, ФРАЬWOЪ 1-800-370-4526.
Chinese -	如欲使用免費語言服務,請致電 1-800-370-4526.
Choctaw -	Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-800-370-4526.
Cushite -	Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-800-370-4526.
Dutch -	Voor gratis toegang tot taaldiensten, bell 1-800-370-4526.
French -	Afin d'accéder aux services langagiers sans frais, composez le 1-800-370-4526.
French Creole -	Pou jwenn sèvis lang gratis, rele 1-800-370-4526.
German -	Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-800-370-4526 an.
Greek -	Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-800-370-4526.
Gujarati -	તમારેકોઇ જાતના ખર્ચવિના ભાષાની સેિાઓની પહોોંર્ માટે, કોલ કરો1-800-370-4526.

Hawaiian -	No ka wala'au 'ana me ka lawelawe 'ōlelo e kahea aku i kēia helu kelepona 1-800-370-4526. Kāki 'ole 'ia kēia kōkua nei.
Hindi -	आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए,1-800-370-4526 पर कॉल करें।
Hmong -	Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-800-370-4526.
lgbo -	lji nwetaòhèrè na ọrụ gasi asụsụ n'efu, kpọọ 1-800-370-4526
llocano -	Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-800-370-4526.
Indonesian -	Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-800-370-4526.
Italian -	Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-800-370-4526.
Japanese -	言語サービスを無料でご利用いただくには、1-800-370-4526 までお電話ください。
Karen -	လၢတၢ်ကမၤန္နာ်ကိုဉ်အတၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖဉ်လၢတအိဉ်ဒီးအၦ္ဒၤလၢကဘာ်ဟ့ဉ်အီၤအဂ်ိၢဘာ်နှဉ် ကိႊ 1-800-370-4526 တက္ၢ်
Korean -	무료 언어 서비스를 이용하려면 1-800-370-4526 번으로 전화해 주십시오.
Kru-Bassa -	Μ dyi wuqu-dù kà kò qò ɓĕ dyi mɔú ń nì Pídyi ní, nìí, qá nɔ́ɓà nìà kɛ: 1-800-370-4526
Kurdish -	بۆ دەسپێړاگەيشتن بە خزمەتگوزارى زمان بەبىێ نێچوون بۆ تۆ، پەيوەندى بكە بە ژمارەي 4526-370-800-1
Laotian -	ເພື່ອເຂົ້າໃຊ້ການບໍລຶການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-800-370-4526
Marathi -	कोणत्याही शल्ुकालशवाय भाषा सेवा प्राप्त करण्यासाठी,, 1-800-370-4526 वर फोन करा.
Marshallese - Micronesian-	Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-800-370-4526.
Pohnpeyan -	Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-800-370-4526.
Mon-Khmer, Cambodian -	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-800-370-4526 ។
Navajo -	T'áá ni nizaad k'ehjí bee níká a'doowoł doo bą́ą́h ílínígóó kojį' hólne' 1-800-370-4526.
Nepali -	निःशुल्क भाषा सेवा प्राप्त गर्न 1-800-370-4526 मा टेलिफोन गर्नुहोस् ।
Nilotic-Dinka -	Të koor yïn weër de thokic ke cïn wëu kor keek tënon yïn. Ke col koc ye koc kuony ne nomba 1-800-370-4526.
Norwegian -	For tilgang til kostnadsfri språktjenester, ring 1-800-370-4526.
•	Um Schprooch Services zu griege mitaus Koscht, ruff 1-800-370-4526.
Persian -	برای دسترسی به خدمات زبان به طور رایگان، با شماره 4526-370-1800 تماس بگیرید .
Polish - Portuguese -	Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-800-370-4526. Para acessar os serviços de idiomas sem custo para você, ligue para 1-800-370-4526.
ruluyuese -	raia alessai us seiviçus de idiomas sem cusio para vole, iigue para 1-000-570-4520.

Punjabi -	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-800-370-4526 'ਤੇ ਫ਼ੋਨ ਕਰੋ।
Romanian -	Pentru a accesa gratuit serviciile de limbă, apelați 1-800-370-4526.
Russian -	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-800-370-4526.
Samoan -	Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-800-370-4526.
Serbo-Croatian -	Za besplatne prevodilačke usluge pozovite 1-800-370-4526.
Spanish -	Para acceder a los servicios de idiomas sin costo, llame al 1-800-370-4526.
Sudanic-Fulfude -	Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-800-370-4526.
Swahili -	Kupata huduma za lugha bila malipo kwako, piga 1-800-370-4526.
Syriac -	:رمح، مد بقه، ما بعته، جل بيلخ بن الله بن ما بحث ب
Tagalog -	Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-800-370-4526.
Telugu -	మీరు భాష సేవలను ఉచితంగా అందుకునందుకు, 1-800-370-4526 కు కాల్ చేయండి.
Thai -	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-800-370-4526.
Tongan -	Kapau 'oku ke fiema'u ta'etōtōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-800-370-4526.
Trukese -	Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-800-370-4526.
Turkish -	Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-800-370-4526 numarayı arayın.
Ukrainian -	Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-800-370-4526.
Urdu -	بالقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 4526-370-1800 پر بات کریں۔
Vietnamese -	Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-800-370-4526
Yiddish -	צו צוטריט שפרַאך בַאדינונגען אין קיין פרייַז צו איר, רופן 1-800-370-4526 צו צוטריט שפרַאך ג
Yoruba -	Lati wọnú awọn isẹ èdè l'ofẹ fun o, pe 1-800-370-4526.