



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/sbcsearch/getpolicydocs?u=080400-080020-032356> or by calling 1-800-261-2441. 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 1-800-261-2441 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For each Plan Year, In-Network Designated: Individual \$1,500 / Family \$3,000. Out-of-Network: Individual \$5,250 / Family \$10,500.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Emergency care & prescription drugs; plus in-network office visits & preventive care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network Designated: Individual \$4,000 / Family \$8,000. Out-of-Network: Individual \$15,000 / Family \$30,000.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover & penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See http://www.myplanportal.com/dse/custom/texashealthaetna or call 1-800-261-2441 for a list of in-network designated providers. Select Open Access Managed Plus.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Designated Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit, <u>deductible</u> doesn't apply	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply	40% <u>coinsurance</u>	None
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	40% <u>coinsurance</u> , except no charge for immunizations up to age 6	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	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.aetnapharmacy.com/advancedcontrolaetna	Preferred generic drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$15 for 30 day supply (retail), \$30 for 31-90 day supply (retail & mail order)	20% <u>coinsurance</u> after <u>copay</u> /prescription, <u>deductible</u> doesn't apply: \$15 for 30 day supply (retail), \$30 for 31-90 day supply (retail & mail order)	Covers 30 day supply (retail), 31-90 day supply (retail & mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in- <u>network</u> . Review your <u>formulary</u> for prescriptions requiring precertification or step therapy for coverage. Your cost will be higher for choosing Brand over Generics.
	Preferred brand drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$30 for 30 day supply (retail), \$60 for 31-90 day supply (retail & mail order)	20% <u>coinsurance</u> after <u>copay</u> /prescription, <u>deductible</u> doesn't apply: \$30 for 30 day supply (retail), \$60 for 31-90 day supply (retail & mail order)	
	Non-preferred generic/brand drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$60 for 30 day supply (retail), \$120 for 31-90 day supply (retail & mail order)	20% <u>coinsurance</u> after <u>copay</u> /prescription, <u>deductible</u> doesn't apply: \$60 for 30 day supply (retail), \$120 for 31-90 day supply (retail & mail order)	
	<u>Specialty drugs</u>	Applicable cost as noted	Not covered	All prescriptions must be filled through the

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Designated Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		above for generic or brand drugs		Aetna Specialty Pharmacy <u>Network</u> .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u> after \$250 <u>copay</u> /visit, <u>deductible</u> doesn't apply	20% <u>coinsurance</u> after \$250 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Out-of-network emergency use paid the same as in- <u>network</u> . No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u> after \$200 <u>copay</u> /trip, <u>deductible</u> doesn't apply	20% <u>coinsurance</u> after \$200 <u>copay</u> /trip, <u>deductible</u> doesn't apply	Out-of-network emergency use paid the same as in- <u>network</u> . Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	\$75 <u>copay</u> /visit, <u>deductible</u> doesn't apply	40% <u>coinsurance</u>	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply; other outpatient services: 20% <u>coinsurance</u>	Office & other outpatient services: 40% <u>coinsurance</u>	None
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If you are pregnant	Office visits	No charge	40% <u>coinsurance</u>	Cost sharing does not apply for <u>preventive services</u> . Maternity care may include tests and 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.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Designated Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	60 visits/ <u>plan</u> year combined with private-duty nursing. Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Rehabilitation services</u>	\$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply	40% <u>coinsurance</u>	20 visits/ <u>plan</u> year for Physical, Occupational & Speech Therapy combined.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <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.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If your child needs dental or eye care	Children's eye exam	No charge	40% <u>coinsurance</u>	1 routine eye exam/24 months.
	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:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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 - 10 visits/plan year for disease, injury & chronic pain.
- Chiropractic care - 20 visits/plan year.
- Hearing aids - 1 hearing aid per ear/3 years.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Private-duty nursing - Included as part of home health care.
- Routine eye care (Adult) - 1 routine eye exam/24 months.

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: Texas Department of Insurance, 1-800-252-3439 (Consumer HelpLine), (512) 676-6000 (Local), (800) 578-4677 (Toll-Free),

www.tdi.texas.gov/consumer/get-help-with-an-insurance-complaint.html.

- 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 www.dol.gov/ebsa/healthreform.
- For more information on your rights to continue coverage, contact the [plan](#) at 1-800-261-2441.
- For non-federal governmental group health [plans](#), you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church [plan](#), church [plans](#) are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how 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:

- 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 toll free number at 1-800-261-2441. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- Texas Department of Insurance, 1-800-252-3439 (Consumer HelpLine), (512) 676-6000 (Local), (800) 578-4677 (Toll-Free), www.tdi.texas.gov/consumer/get-help-with-an-insurance-complaint.html.
- For non-federal governmental group health [plans](#), you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your [appeal](#). Contact Texas Department of Insurance, Consumer Protection, Mail Code 111-1A, 333 Guadalupe, P.O. Box 149091, Austin, TX 78714-9091, Phone toll-free: 1-800-252-3439, <http://www.texashealthoptions.com>, ConsumerProtection@tdi.texas.gov

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 [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>	\$1,500
■ <u>Specialist</u> copayment	\$50
■ 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	\$12,700
In this example, Peg would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$2,000
<u>What isn't covered</u>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,570

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>	\$1,500
■ <u>Specialist</u> copayment	\$50
■ 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
Diabetic supplies (*glucose meter*)

Total Example Cost	\$5,600
In this example, Joe would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$1,200
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,320

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist</u> copayment	\$50
■ 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>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$400
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Mia would pay is	\$700

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: 1-800-261-2441.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-261-2441.

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

Texas Health 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,
1-800-648-7817, TTY: 711,
Fax: 859-425-3379, 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).

Texas Health Aetna is the brand name used for products and services provided by Texas Health + Aetna Health Insurance Company and Texas Health + Aetna Health Plan Inc. Health benefits and health insurance plans are offered and/or insured by Texas Health + Aetna Health Plan Inc. and Texas Health + Aetna Health Insurance Company (Texas Health Aetna). Each insurer has sole financial responsibility for its own products. Texas Health Aetna is an affiliate of Texas Health Resources and of Aetna Life Insurance Company and its affiliates (Aetna). Aetna provides certain management services to Texas Health Aetna. Self-funded plans are administered by Texas Health + Aetna Health Insurance Company.

TTY: 711

Language Assistance:

For language assistance in your language call 1-800-261-2441 at no cost.

Albanian -	Për shërbime përkthimi falas për ju, telefononi 1-800-261-2441.
Amharic -	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-800-261-2441 ይደውሉ።
Arabic -	مقررا إلى ع لاصتالاء اجرال، قفلكت ي أ نود ةيوعللل اتامدخل إلى ع لوصحلل 1-800-261-2441
Armenian -	Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-800-261-2441 հեռախոսահամարով:
Bahasa-Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-261-2441 tanpa dikenakan biaya.
Bantu-Kirundi -	Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-800-261-2441.
Bengali-Bangala -	আপনাকে বিনামূল্যে ভাষা পবকিসাি পপকে হকয এই নম্বকি পবেযক ান ব্রুন: 1-800-261-2441।
Bisayan-Visayan -	Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-800-261-2441.
Burmese -	သင့်အနေဖြင့် အခကြေးငွေ မပေးရပဲ ဘာသာစကားဝန်ဆောင်မှုများ ရရှိနိုင်ရန် 1-800-261-2441 သို့ ဖုန်းခေါ်ဆိုပါ။
Catalan -	Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-800-261-2441.
Chamorro -	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-800-261-2441.
Cherokee -	Ⴄႃ႗ႃ Ⴑ႗ႃ႗ႃ Ⴑ႗ႃ႗ႃ Ⴑ႗ႃ႗ႃ Ⴑ႗ႃ႗ႃ Ⴑ႗ႃ႗ႃ Ⴑ႗ႃ႗ႃ Ⴑ႗ႃ႗ႃ 1-800-261-2441.
Chinese -	如欲使用免費語言服務，請致電 1-800-261-2441。
Choctaw -	Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-800-261-2441.
Cushite -	Tajaajiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-800-261-2441.
Dutch -	Voor gratis toegang tot taaldiensten, bell 1-800-261-2441.
French -	Afin d'accéder aux services langagiers sans frais, composez le 1-800-261-2441.
French Creole -	Pou jwenn sèvis lang gratis, rele 1-800-261-2441.
German -	Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-800-261-2441 an.
Greek -	Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-800-261-2441.

Gujarati -	તમારે કોઇ જાતના ખર્ચ વાનિ ભાષાની સેલિઓની પહોર માટે, કોલ કરો 1-800-261-2441.
Hawaiian -	No ka wala'au 'ana me ka lawelawe 'ōlelo e kahea aku i kēia helu kelepona 1-800-261-2441 Kāki 'ole 'ia kēia kōkua nei.
Hindi -	आपके लिए बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लएि, 1-800-261-2441 पर कॉल करें।
Hmong -	Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-800-261-2441.
Igbo -	Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ 1-800-261-2441.
Ilocano -	Tapno maaksesyô dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-800-261-2441.
Indonesian -	Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-800-261-2441.
Italian -	Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-800-261-2441.
Japanese -	言語サービスを無料でご利用いただくには、1-800-261-2441 までお電話ください
Karen -	လၢတၢ်ကမၤန့ၢ်ကိၣ်အတၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖၣ်လၢတအိၣ်ဒီးအပူၤလၢကဘၣ်ဟ့ၣ်အိၣ်အဂီၢ်ဘၣ်န့ၣ် ကိး 1-800-261-2441 တက့ၢ်.
Korean -	무료 언어 서비스를 이용하려면 1-800-261-2441 번으로 전화해 주십시오.
Kru-Bassa -	M dyi wuḍu-dù kà kò dò bě dyi móuń ñì Pídyi ní, nìí, dá nòbà nìà kɛ: 1-800-261-2441.
Kurdish -	1-800-261-2441 یەرامژ مە مەکەب یەدەنەوی مە پ، وە ت و ب نو و چ ئێ ت ئ ب مە نامز یراز و گەت مە ز مە خ مە ب ن ت ش ی ه گ ا ر ئ پ س ه د و ب
Laotian -	ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕົວກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-800-261-2441.
Marathi -	कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी 1-800-261-2441 वर फोन करा.
Marshallese -	Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlök 1-800-261-2441.
Micronesian Pohnpeyan -	Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-800-261-2441.
Mon-Khmer Cambodian -	ដើម្បីប្រើប្រាស់សេវាភាសាដោយឥតគិតថ្លៃសម្រាប់អ្នកខ្មែរ មុនពេលទូរស័ព្ទសេវាភាសាសូម 1-800-261-2441។
Navajo -	T'áá ni nizaad k'ehjí bee níká a'doowol doo bą́ą́h ílínígóó kojí' hólne' 1-800-261-2441.
Nepali -	निःशुल्क भाषा सेवा प्राप्त गनन 1-800-261-2441 मा टेलिफोन गनुनहोस् ।
Nilotic-Dinka -	Të kɔɔr yin wëër de thokic ke cîn wëu kɔr keek tënɔŋ yîn. Ke cɔl kɔc ye kɔc kuɔny ne nɔmba 1-800-261-2441.
Norwegian -	For tilgang til kostnadsfri språktjenester, ring 1-800-261-2441.

Pennsylvania Dutch - Um Schprooch Services zu griege mitaus Koscht, ruff 1-800-261-2441.

Persian - ڊيري گب سامت 1-800-261-2441 مرامش اب، ن اگي ار روط هب نابز تامدخ هب ي سرتسد ي ارب

Polish - Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-800-261-2441.

Portuguese - Para acessar os serviços de idiomas sem custo para você, ligue para 1-800-261-2441.

Punjabi - ਤੁਹਾਡੇ ਲਈ ਬਨਿਾਂ ਬਸਿੇ ਮਿਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਰਿਨ ਲਈ, 1-800-261-2441 'ਤੇ ਫ਼ੋਨ ਰਿੰ।

Romanian - Pentru a accesa gratuit serviciile de limbă, apelati 1-800-261-2441.

Russian - Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-800-261-2441.

Samoan - Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-800-261-2441.

Serbo-Croatian - Za besplatne prevodilačke usluge pozovite 1-800-261-2441.

Spanish - Para acceder a los servicios de idiomas sin costo, llame al 1-800-261-2441.

Sudanic-Fulfulde - Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-800-261-2441.

Swahili - Kupata huduma za lugha bila malipo kwako, piga 1-800-261-2441.

Syriac - : ܡܫܝܚܐ ܕܥܠܡܐ ܕܩܕܝܫܐ ܕܡܪܝܬܐ ܕܡܨܝܬܐ ܕܡܨܝܬܐ ܕܡܨܝܬܐ 1-800-261-2441.

Tagalog - Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-800-261-2441.

Telugu - మేరు భష సేవలను ఉచితంగా అందుకునందుకు, 1-800-261-2441 కు కల్ చేయండి.

Thai - หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-800-261-2441.

Tongan - Kapau 'oku ke fiema'u ta'etōtōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-800-261-2441.

Trukese - Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-800-261-2441.

Turkish - Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-800-261-2441 numarayı arayın.

Ukrainian - Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-800-261-2441.

Urdu - سیرک تا ب رپ 1-800-261-2441 سے مل کے سیرک لصاح تا مدخ مقل عتم سے نابز تم می قل اب۔

Vietnamese - Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-800-261-2441.

Yiddish - צו צוטריט ראָרפּש באַדינונגען אין קיין פּרייַז צו איר, רופן 1-800-261-2441

Yoruba - Lati wonú awon ise èdè l’ofe fun o, pe 1-800-261-2441.