



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.tractivecareetna.com or call 1-800-222-9205. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-800-222-9205 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	For each <u>Plan Year</u> , In- <u>Network</u> : Individual \$1,000 / Family \$3,000. Out-of- <u>Network</u> : Individual \$2,000 / 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 <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Prescription drugs</u> ; plus in- <u>network</u> office visits, <u>urgent care</u> visits & <u>preventive care</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.tractivecareetna.com
Are there other <u>deductibles</u> for specific services?	Yes. \$200 for <u>prescription drug</u> expenses. Doesn't apply to generic drugs. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	In- <u>Network</u> : Individual \$7,900 / Family \$15,800. Out-of- <u>Network</u> : Individual \$23,700 / Family \$47,400.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, bariatric surgery <u>copays</u> , 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.tractivecareetna.com or call 1-800-222-9205 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 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 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 Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply; except 20% <u>coinsurance</u> for office surgery	40% <u>coinsurance</u>	Includes Internist, General Physician, Family Practitioner, Pediatrician or Gynecologist.
If you visit a health care <u>provider's</u> office or clinic	<u>Specialist</u> visit	\$70 <u>copay</u> /visit, <u>deductible</u> doesn't apply; except 20% <u>coinsurance</u> for office surgery	40% <u>coinsurance</u>	None
If you visit a health care <u>provider's</u> office or clinic	<u>Preventive care</u> / <u>screening</u> /immunization	No charge, except \$70 <u>copay</u> /visit, <u>deductible</u> doesn't apply, for hearing or eye exam	40% <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 TRS Virtual Health visit	TRS Virtual Health video/phone consult	No charge	NA	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you have a test	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u> after \$100 <u>copay</u> /visit	40% <u>coinsurance</u> after \$100 <u>copay</u> /visit	Pre-authorization may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p>If you need drugs to treat your illness or condition Prescription drug coverage is administered by CVS/Caremark More information about prescription drug coverage is available at www.cvscaremark.com</p>	Generic drugs	<p><u>Copay/prescription, deductible</u> doesn't apply: \$20 (Retail first fill), \$35 (Retail refill), \$45 (Mail Order or Retail-Plus)</p>	<p><u>Copay/prescription, deductible</u> doesn't apply: \$20 (Retail first fill), \$35 (Retail refill), \$45 (Mail Order or Retail-Plus)</p>	<p>Covers 31-day supply (Retail), 60-90 day supply (Mail Order & Retail-Plus). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives <u>in-network</u>. Precertification & step therapy required. Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written. Out-of-Network: reimbursement is the <u>allowed amount</u> for what would have been charged by a <u>network</u> pharmacy less the <u>copay</u> after the drug <u>deductible</u> is met.</p>
<p>If you need drugs to treat your illness or condition Prescription drug coverage is administered by CVS/Caremark More information about prescription drug coverage is available at www.cvscaremark.com</p>	Preferred brand drugs	<p><u>Copay/prescription: 25% coinsurance, after specific deductible:</u> minimum \$40/maximum \$80 (Retail first fill), minimum \$60/maximum \$120 (Retail refill), minimum \$105/maximum \$210 (Mail Order or Retail-Plus)</p>	<p><u>Copay/prescription: 25% coinsurance, after specific deductible:</u> minimum \$40/maximum \$80 (Retail first fill), minimum \$60/maximum \$120 (Retail refill), minimum \$105/maximum \$210 (Mail Order or Retail-Plus)</p>	<p>Covers 31-day supply (Retail), 60-90 day supply (Mail Order & Retail-Plus). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives <u>in-network</u>. Precertification & step therapy required. Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written. Out-of-Network: reimbursement is the <u>allowed amount</u> for what would have been charged by a <u>network</u> pharmacy less the <u>copay</u> after the drug <u>deductible</u> is met.</p>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p>If you need drugs to treat your illness or condition</p> <p>Prescription drug coverage is administered by CVS/Caremark</p> <p>More information about prescription drug coverage is available at www.cvscaremark.com</p>	Non-preferred brand drugs	<p><u>Copay/prescription:</u> 50% <u>coinsurance</u>, after specific <u>deductible</u>: minimum \$100/maximum \$200 (Retail first fill), minimum \$105/maximum \$210 (Retail refill), minimum \$215/maximum \$430(Mail Order or Retail-Plus)</p>	<p><u>Copay/prescription:</u> 50% <u>coinsurance</u>, after specific <u>deductible</u>: minimum \$100/maximum \$200 (Retail first fill), minimum \$105/maximum \$210 (Retail refill), minimum \$215/maximum \$430(Mail Order or Retail-Plus)</p>	Covers 31-day supply (Retail), 60-90 day supply (Mail Order & Retail-Plus). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in-network. Precertification & step therapy required. Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written. Out-of-Network: reimbursement is the <u>allowed amount</u> for what would have been charged by a <u>network</u> pharmacy less the <u>copay</u> after the drug <u>deductible</u> is met.
<p>If you need drugs to treat your illness or condition</p> <p>Prescription drug coverage is administered by CVS/Caremark</p> <p>More information about prescription drug coverage is available at www.cvscaremark.com</p>	<u>Specialty drugs</u>	<p>20% <u>coinsurance</u> after specific <u>deductible</u>, minimum \$200/maximum \$900</p>	<p>20% <u>coinsurance</u> after specific <u>deductible</u>, minimum \$200/maximum \$900</p>	All <u>Specialty drugs</u> must be filled at Specialty Pharmacy. Retail not covered. 31-day supply limit.
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	<p>20% <u>coinsurance</u> after \$150 <u>copay/visit</u></p>	<p>40% <u>coinsurance</u> after \$150 <u>copay/visit</u></p>	None
<p>If you have outpatient surgery</p>	Physician/surgeon fees	<p>20% <u>coinsurance</u></p>	<p>40% <u>coinsurance</u></p>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care (hospital affiliated facility)</u> <u>Emergency room care (freestanding facility)</u>	20% <u>coinsurance</u> : \$250 <u>copay</u> /visit \$500 <u>copay</u> /visit	20% <u>coinsurance</u> : \$250 <u>copay</u> /visit \$500 <u>copay</u> /visit	40% <u>coinsurance</u> for non-emergency use out-of-network.
If you need immediate medical attention	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Non-emergency transport: not covered, except if pre-authorized.
If you need immediate medical attention	<u>Urgent care</u>	\$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply	40% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u> after \$150 <u>copay</u> /day first 5 days	40% <u>coinsurance</u> ; Member pays the balance of charge in excess of \$500 per day after <u>deductible</u>	Maximum/ <u>plan</u> year per individual, in network facility copay: \$2,250. Penalty of \$250 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If you have a hospital stay	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 & other outpatient visits: \$70 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Office & other outpatient visits: 40% <u>coinsurance</u>	<u>Pre-authorization</u> may be required for care.
If you need mental health, behavioral health, or substance abuse services	TRS Virtual Health video consult	\$70 <u>copay</u> /visit, <u>deductible</u> doesn't apply	NA	Consults can be with a psychiatrist, psychologist, licensed clinical social worker, counselor or therapist
If you need mental health, behavioral health, or substance abuse services	Inpatient services	20% <u>coinsurance</u> after \$150 <u>copay</u> /day first 5 days	40% <u>coinsurance</u> ; Member pays the balance of charge in excess of \$500 per day after <u>deductible</u>	Maximum/ <u>plan</u> year per individual, in network facility copay: \$2,250. Penalty of \$250 for failure to obtain <u>pre-authorization</u> for out-of-network care.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
If you are pregnant	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
If you are pregnant	Childbirth/delivery facility services	20% <u>coinsurance</u> after \$150 <u>copay</u> /day first 5 days	40% <u>coinsurance</u> ; Member pays the balance of charge in excess of \$500 per day after <u>deductible</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Maximum facility copay/ <u>plan</u> year per individual: \$2,250. Penalty of \$250 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
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. <u>Pre-authorization</u> may be required for out-of-network care.
If you need help recovering or have other special health needs	<u>Rehabilitation services</u>	\$70 <u>copay</u> /visit, <u>deductible</u> doesn't apply	40% <u>coinsurance</u>	None
If you need help recovering or have other special health needs	<u>Habilitation services</u>	\$70 <u>copay</u> /visit, <u>deductible</u> doesn't apply	40% <u>coinsurance</u>	Limited to treatment of autism and to speech therapy for developmental delay.
If you need help recovering or have other special health needs	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	25 days/ <u>plan</u> year. Penalty of \$250 for failure to obtain <u>pre-authorization</u> for out-of-network care.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network 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>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.
If you need help recovering or have other special health needs	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Penalty of \$250 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
If your child needs dental or eye care	Children's eye exam	\$70 <u>copay/visit</u> , <u>deductible</u> doesn't apply	40% <u>coinsurance</u>	1 routine eye exam/ <u>plan</u> year if performed by an ophthalmologist or optometrist.
If your child needs dental or eye care	Children's glasses	Not covered	Not covered	Not covered.
If your child needs dental or eye care	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

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

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs - Except for required preventive services.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery - Limited to Institutes of Quality facility for in-network only. \$5000 copay.
- Chiropractic care - 35 visits/plan year.
- Hearing aids - \$1,000 maximum/36 months.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Routine eye care (Adult) - 1 routine eye exam/plan year.

Your Rights to Continue Coverage:

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

For more information on your rights to continue coverage, contact the plan at 1-800-222-9205.

- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or : <https://www.dol.gov/agencies/ebsa>
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- 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 to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-800-222-9205.

- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa>
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: <http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html>.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

-----*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*-----

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$1,000
- Specialist copayment \$70
- Hospital (facility) coinsurance 20%
- Other coinsurance 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:

<i>Cost Sharing</i>	
Deductibles*	\$1,000
Copayments	\$100
Coinsurance	\$2,300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,460

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

- The plan's overall deductible \$1,000
- Specialist copayment \$70
- Hospital (facility) coinsurance 20%
- Other coinsurance 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:

<i>Cost Sharing</i>	
Deductibles*	\$300
Copayments	\$1,900
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,220

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

- The plan's overall deductible \$1,000
- Specialist copayment \$70
- Hospital (facility) coinsurance 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	\$1,900
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles*	\$1,000
Copayments	\$300
Coinsurance	\$70
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,370

Note: If your plan has a wellness program and you choose to participate, you may be able to reduce your costs.

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-222-9205.

Smartphone or Tablet

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

Non-Discrimination

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

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

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

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),

1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705),

Email: CRCoordinator@aetna.com.

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 (Aetna).

- Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-800-222-9205. Kāki ‘ole ‘ia kēia kōkua nei.
- Hindi - हनिदी में भाषा सहायता के लिए, 1-800-222-9205 पर मुफ्त कॉल करें।
- Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-222-9205.
- Ibo - Maka enyemaka asụsụ na Igbo kpọọ 1-800-222-9205 na akwụghị ụgwọ ọ bụla
- Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-222-9205 nga awan ti bayadanyo.
- Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-222-9205.
- Japanese - 日本語で援助をご希望の方は、1-800-222-9205 まで無料でお電話ください。
- Karen - လာဘာမရဘဲလဲကတိတ်ကျိပ်အင်္ဂါ ကျိပ် ကိး 1-800-222-9205 လာဘာအိတ်ဒီးဘာလာဘာကျိပ်လာဘာကျိပ်
- Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-222-9205 번으로 전화해 주십시오.
- Kru-Bassa - Ɖe m'ké gbo-kpá-kpá dyé pídyi dé Ɖašwó-wuḍuŋ wěɛ, dǎ 1-800-222-9205
- Kurdish - برابى راهنمايى به زبان فارسى با شماره 1-800-222-9205 به خورايى پهيو مندى بکەن.
- Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-800-222-9205 ໂດຍບໍ່ເສຍຄ່າໂທ.
- Marathi - तीलभाषा (मराठी) सहाय्यासाठी 1-800-222-9205 क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.
- Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-222-9205 ilo ejjelok wōnān.
- Micronesian-Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-222-9205 ni sohte isais.
- Mon-Khmer, Cambodian - សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទេពកាន់លេខ 1-800-222-9205 ដោយឥតគិតថ្លៃ។
- Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-800-222-9205
- Nepali - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-800-222-9205 मा फोन गर्नुहोस् ।
- Nilotic-Dinka - Tën kuwoɲy ë thok ë Thuɔɲjäɲ ɔɔl 1-800-222-9205 kec'in ayöc.
- Norwegian - For språkassistanse på norsk, ring 1-800-222-9205 kostnadsfritt.
- Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-222-9205 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।
- Pennsylvania Dutch - Fer Hefle in Deitsch, ruf: 1-800-222-9205 aa. Es Aaruf koschtet nix.
- Persian - برای راهنمایی به زبان فارسی با شماره 1-800-222-9205 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
- Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-222-9205.

