This is only a summary. Please read the FEHB Plan brochure RI 73-828 that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure.** Benefits may vary if you have other coverage, such as Medicare. You can get the FEHB Plan brochure at www.AetnaFeds.com or by calling 1-888-238-6240.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Participating: Self **$1,500** / Self Plus One or Self and Family $**3,000**. Non-Participating: Self **$1,500** / Self Plus One or Self and Family $**3,000**. Does not apply to preventive care in-network.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for certain covered services. When a covered service or supply is subject to a **deductible**, only the Plan allowance for the service or supply counts toward the **deductible**. This plan includes a **$900/$1,800/$1,800** Medical Fund that pays prior to the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. Participating: Self **$5,000**/Self Plus One or Self and Family **$6,850**. Non-Participating: Self **$5,000**/Self Plus One or Self and Family **$10,000**.	The **out-of-pocket limit,** or catastrophic maximum, is the most you could pay during the year for your share of the cost of covered services. This limit helps you plan for health care expenses. The "per covered individual" amount is the most that any one member would have to pay, regardless of whether the individual is enrolled in Self Plus One, or Self and Family.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, penalties for failure to obtain pre-authorization and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of preferred **providers**, see www.aetnafeds.com or call 1-888-238-6240.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See this plan's FEHB brochure for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non- Participating Provider (plus you may be balance billed)	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	——— None ———
	Specialist visit	20% coinsurance	40% coinsurance	——— None ———
	Other practitioner office visit	20% coinsurance	40% coinsurance	——— None ———
	Preventive care/screening/immunization	No charge	40% coinsurance	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	——— None ———
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Pre-authorization may be required.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non- Participating Provider (plus you may be balance billed)	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetna.com/pharmacy- insurance/individuals- families. Value Plus Five Tier Open Formulary	Formulary generic drugs	After deductible, copay/prescription $5 (retail), $0 (mail order)	After deductible: 50% coinsurance plus the difference between our plan allowance and the billed amount	Covers 30-day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs and devices obtainable from a pharmacy. No charge for formulary generic FDA-approved women's contraceptives from preferred pharmacy. Review your formulary for prescriptions requiring precertification or step therapy for coverage. Your cost will be higher for choosing Brand over Generics.
	Formulary brand drugs	After deductible: 30% coinsurance up to a $600 maximum/ prescription (retail), $60 copay/ prescription (mail order)	After deductible: 50% coinsurance plus the difference between our plan allowance and the billed amount	
	Non-formulary brand drugs	After deductible: 50% coinsurance up to a $600 maximum/ prescription (retail), $105 copay/ prescription (mail order)	After deductible: 50% coinsurance plus the difference between our plan allowance and the billed amount	

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider (plus	Limitations & Exceptions
	Specialty drugs	Preferred: 50% coinsurance up to a $600 maximum, Non-preferred: 50% up to a $1,200 maximum/ prescription.	Not covered	First prescription must be filled at a participating retail pharmacy or Aetna Specialty Pharmacy Networks. Subsequent fills must be through Aetna Specialty Pharmacy Networks.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	——— None ———
	Physician/surgeon fees	20% coinsurance	40% coinsurance	——— None ———
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	No coverage for non-emergency use.
	Emergency medical transportation	20% coinsurance	20% coinsurance	——— None ———
	Urgent care	20% coinsurance	20% coinsurance	40% coinsurance for out-of-network non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Pre-authorization required for care.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	——— None ———
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	40% coinsurance	——— None ———
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	Pre-authorization required for care.
	Substance use disorder outpatient services	20% coinsurance	40% coinsurance	——— None ———
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	Pre-authorization required for care.
If you are pregnant	Prenatal and postnatal care	No charge for prenatal care and first postnatal visit	40% coinsurance	Subsequent postnatal visits 20% coinsurance for preferred providers and 40% coinsurance for non-participating providers.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non- Participating Provider (plus you may be balance billed)	Limitations & Exceptions
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	Pre-authorization may be required for care. Includes outpatient postnatal care.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Coverage is limited to 3 visits per day up to 4 hours per visit. Pre-authorization required for care.
	Rehabilitation services	20% coinsurance	40% coinsurance	Coverage is limited to 60 visits per calendar year for Physical & Occupational Therapy combined, 60 visits per calendar year for Speech Therapy.
	Habilitation services	20% coinsurance	40% coinsurance	Coverage is limited to 60 visits per calendar year for Physical & Occupational Therapy combined, 60 visits per calendar year for Speech Therapy.
	Skilled nursing care	20% coinsurance	40% coinsurance	Coverage is limited to 60 days per calendar year. Pre-authorization required for care.
	Durable medical equipment	20% coinsurance	40% coinsurance	———— None ————
	Hospice service	20% coinsurance	40% coinsurance	Pre-authorization required.
If your child needs dental or eye care	Eye exam	No charge	40% coinsurance	Coverage is limited to 1 routine eye exam per 12 months.
	Glasses	Not covered	Not covered	Not covered.
	Dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check this plan's FEHB brochure for other excluded services.)

- Chiropractic care
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Questions: Call 1-888-238-6240 or visit us at www.AetnaFeds.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary.
You can view the Glossary at www.AetnaFeds.com or call 1-888-238-6240 to request a copy.

Other Covered Services (This isn't a complete list. Check this plan's FEHB brochure for other covered services and your costs for these services.)

- Acupuncture – Covered in lieu of anesthesia.
- Bariatric surgery
- Infertility treatment – Benefit limitations may apply.
- Routine eye care (Adult) – Coverage is limited to 1 routine eye exam per 12 months.
- Routine foot care – Coverage is limited to active treatment for a metabolic or peripheral vascular disease.
- Weight loss programs – Coverage is limited to dietary and nutritional counseling.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, to convert to an individual policy, and to receive temporary continuation of coverage (TCC). Your TCC rights will be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. An individual policy may also provide different benefits than you had while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, see the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at 1-888-238-6240 or visit www.opm.gov.insure/health.

Your Grievance and Appeal Rights:

If you are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal**. For information about your **appeal** rights please see Section 3, "How you get care," and Section 8 "The disputed claims process," in your plan's FEHB brochure. If you need assistance, you can contact: 1-888-238-6240.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **Coverage under this plan qualifies as minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.**

Language Access Services:

Para obtener asistencia en Español, llame al 1-888-238-6240.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-238-6240.

如果需要中文的帮助，请拨打这个号码1-888-238-6240.

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-238-6240.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,130
- **Patient pays** $2,410

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,500
Copays	$10
Coinsurance	$700
Limits or exclusions	$200
Total	**$2,410**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,420
- **Patient pays** $1,980

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,500
Copays	$200
Coinsurance	$200
Limits or exclusions	$80
Total	**$1,980**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of- pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-238-6240.

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 on the basis of race, color, national origin, age, disability, or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aetna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 14462, Lexington, KY 40512, 1-800-648-7817, TTY 711, Fax 859-425-3379, CRCoordinator@aetna.com.

California HMO/HNO Members: Civil Rights Coordinator, PO Box 24030 Fresno CA, 93779, 1-800-648-7817, TTY 711, Fax 860-262-7705, CRCoordinator@aetna.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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 1-888-238-6240 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-888-238-6240.
Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-888-238-6240 በነጻ ይደውሉ·
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-888-238-6240
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-888-238-6240 առանց գնով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-238-6240 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-888-238-6240 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-888-238-6240-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-238-6240 nga walay bayad.
Burmese -	ဌေးကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-888-238-6240 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-888-238-6240.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-888-238-6240 sin gåstu.
Cherokee -	ᎾᏍᎩᎾ ᎦᏬᏂᎯᏍᏗ ᏗᏂᏍᎦᏢᏍᎩ ᎾᏂᎢ (ᏣᎳᎩ) ᎧᏲᎳᏫᏍ 1-888-238-6240 ᎤᎾᎢ Ꮭ ᎪᎢᏍᏗ ᏧEᏩᏢᏗ ᏂᏣᎡᎾ.
Chinese -	欲取得繁體中文語言協助，請撥打 1-888-238-6240，無需付費。
Choctaw -	(Chahta) anumpa ya apela a chi l paya hinla 1-888-238-6240.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-888-238-6240 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-888-238-6240.
French -	Pour une assistance linguistique en français appeler le 1-888-238-6240 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-238-6240 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-238-6240 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-238-6240 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-888-238-6240 પર કોલ કરો.

Hawaiian -	No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-888-238-6240. Kāki ‘ole ‘ia kēia kōkua nei.
Hindi -	हिन्दी में भाषा सहायता के लिए, 1-888-238-6240 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-238-6240.
Ibo -	Maka enyemaka asụsụ na Igbo kpọọ 1-888-238-6240 na akwụghị ụgwọ ọ bụla
Ilocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-238-6240 nga awan ti bayadanyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-238-6240.
Japanese -	日本語で援助をご希望の方は、1-888-238-6240 まで無料でお電話ください。
Karen -	လာတ်မၤစၢတ်ကတိၤကျိာ်အဂီၢ် ကျိာ် ကိး 1-888-238-6240 လာတအိာ်ဒီးတ်လာ်ဘျာ်လာ်စုဟာ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-238-6240번으로 전화해 주십시오.
Kru-Bassa -	Bɛ́m`ké gbo-kpá-kpá dyé pidyi ɖé Ba̋sɔɔ́-wuɖuǔn wɛ́ɛ, ɖá 1-888-238-6240
Kurdish -	برای راهنمایی به زبان فارسی با شماره 1-888-238-6240 به خۆرایی پەیوەندی بکەن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-888-238-6240 ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi -	तीलभाषा (मराठी) सहाय्यासाठी 1-888-238-6240 क्रमांकावरकोणत्याहीखर्चाशवियकॉलकरा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-888-238-6240 ilo ejjelok wōnān.
Micronesian-Pohnpeyan -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-238-6240 ni sohte isais.
Mon-Khmer, Cambodian -	សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-888-238-6240 ដោយឥតគិតថ្លៃ។
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-888-238-6240
Nepali -	(नेपाली) मा नःशुल्क भाषा सहायता पाउनका लागि 1-888-238-6240 मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-888-238-6240 kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-888-238-6240 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-238-6240 ‘ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-888-238-6240 aa. Es Aaruf koschtet nix.
Persian -	برای راهنمایی به زبان فارسی با شماره 1-888-238-6240 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-238-6240.

Portuguese -	Para obter assistência linguística em português ligue para o 1-888-238-6240 gratuitamente.
Romanian -	Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-888-238-6240
Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-888-238-6240.
Samoan -	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-888-238-6240 e aunoa ma se totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-888-238-6240.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-888-238-6240.
Sudanic-Fulfude -	Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-888-238-6240. Njodi woo fawaaki on.
Swahili -	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-888-238-6240 bila malipo.
Syriac -	1-888-238-6240 ܐܬܪ.
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-238-6240 nang walang bayad.
Telugu -	భాషతో సాయం కోరకు ఎలాంటి ఖర్చు లేకుండా 1-888-238-6240 కు కాల్ చేయండి. (తెలుగు)
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-888-238-6240 ฟรีไม่มีค่าใช้จ่าย
Tongan -	Kapau ʻoku fiema'u hā tokoni ʻi he lea faka-Tonga telefoni 1-888-238-6240 ʻo ʻikai hā tōtōngi.
Trukese -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-888-238-6240 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-888-238-6240.
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-238-6240.
Urdu -	1-888-238-6240
Vietnamese -	Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-888-238-6240.
Yiddish -	פאר שפראך הילף אין אידיש רופט 1-888-238-6240 פריי פון אפצאל.
Yoruba -	Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-888-238-6240 lái san owó kankan rárá.