



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](http://www.HealthReformPlanSBC.com) or by calling 1-888-982-3862. 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 1-888-982-3862 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	In <u>Network</u> : \$0. Out-of-Network: Individual \$750 / Family \$1,875.	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 is 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	In-Network: Individual \$3,175 / Family \$6,350. Out-of-Network: Individual \$4,500 / Family \$11,250.	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, 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 <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-888-982-3862 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 charge</u> 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	\$25 <u>copay</u> /visit, <u>deductible</u> doesn't apply; except no charge for office surgery	<u>Deductible</u> + 30% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$30 <u>copay</u> /visit for NYP-Affiliated Specialist; except no charge for office surgery  \$40 <u>copay</u> /visit for non-NYP specialist; except no charge for office surgery		If the place of service the member visits is identified as Facility Setting rather than Office Setting the \$40 copay will apply.
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge		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.
Other specialist visit	Acupuncture	\$0 <u>copay</u> for the first 25 visits of a calendar year and \$25 thereafter	<u>Deductible</u> + 30% <u>coinsurance</u>	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 have a test	<u>Diagnostic test</u> : Blood work	No charge for laboratory	<u>Deductible</u> + 30% coinsurance	None
	<u>Diagnostic test</u> X-ray	\$30 <u>copay</u> /visit with NYP- Affiliated Specialist	<u>Deductible</u> + 30% coinsurance	\$40 copay applies if the service is provided outside of an office visit with an NYP-affiliated specialist.  Additionally if the place of service the member visits is identified as Facility Setting rather than Office Setting the \$40 copay will apply.
	Imaging (CT/PET scans, MRIs)	\$40 <u>copay</u> /visit with non-NYP Specialist		
<u>If you need prescription drugs</u>	Refer to <a href="http://www.caremark.com">www.caremark.com</a>			
Telemedicine	Aetna Teladoc	General Medicine and Mental health; \$25 <u>copay</u> /visit	Not applicable	Telemedicine
		Non-NYP Specialist (i.e., dermatologist): \$40 <u>copay</u> /visit		
	NYP Virtual Urgent Care – Adult and Pediatric	\$0 <u>copay</u> /visit	Not applicable	Telemedicine
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	<u>Deductible</u> + 30% coinsurance	None
	Physician/surgeon fees	No charge	<u>Deductible</u> + 30% coinsurance	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</u>	\$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> . No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	No charge	No charge	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	\$35 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u> after \$35 <u>copay</u> /visit, <u>deductible</u> doesn't apply	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$150 <u>copay</u> /day first 3 days per stay, <u>deductible</u> doesn't apply	<u>Deductible</u> + 30% <u>coinsurance</u>	Max <u>copay</u> /per admission: \$450 in- <u>network</u> . Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Physician/surgeon fees	No charge	<u>Deductible</u> + 30% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copay</u> /Office visit, <u>deductible</u> doesn't apply  Other outpatient services: No charge	Office & other outpatient services:  <u>Deductible</u> + 30% <u>coinsurance</u>	None
	Inpatient services	Facility: No charge \$150 <u>copay</u> /day first 3 days per stay, <u>deductible</u> doesn't apply	<u>Deductible</u> + 30% <u>coinsurance</u>	Max <u>copay</u> /per admission: \$450 in- <u>network</u> . Penalty of \$400 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		<p><u>Cost sharing</u> does not apply for <u>preventive services</u>.</p> <p>Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).</p> <p>Max <u>copay</u>/ per admission: \$450 in-<u>network</u>.</p> <p>Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.</p>
	Childbirth/delivery professional services	No charge	<u>Deductible</u> + 30% <u>coinsurance</u>	<p><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). Max <u>copay</u>/calendar year: \$450 in-<u>network</u>. Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.</p>
	Childbirth/delivery facility services	\$150 <u>copay</u> /day first 3 days per stay, <u>deductible</u> doesn't apply		<p><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). Max <u>copay</u>/calendar year: \$450 in-<u>network</u>. Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.</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)	
<b>If you are seeking gender affirming care</b>	<u>Specialist</u> office visit	\$30 <u>copay</u> /visit for NYP-Affiliated Specialist; except no charge for office surgery  \$40 <u>copay</u> /visit for non-NYP specialist; except no charge for office surgery	<u>Deductible</u> + 30% <u>coinsurance</u>	Coverage for gender affirming care follows the clinical guidelines outlined in CPB #0615 (Gender Affirming Surgery).  Your NYP plan also includes enhanced coverage for gender affirming care. This enhanced coverage is inclusive of the following services:  Facial Feminization surgery Thyroid chondroplasty Rhytidectomy Electrolysis Voice Surgery Jaw surgery
	Outpatient Services: <ul style="list-style-type: none"> <li>Facility fee (e.g., ambulatory surgery center)</li> <li>Physician/surgeon fees</li> </ul>	No charge	<u>Deductible</u> + 30% <u>coinsurance</u>	
	Inpatient services: Facility fee (e.g. hospital room)	\$150 <u>copay</u> /day first 3 days per stay		
	Inpatient services: Physician/surgeon fees	No charge	<u>Deductible</u> + 30% <u>coinsurance</u>	

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)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	No charge	<u>Deductible</u> + 30% <u>coinsurance</u>	200 visits/calendar year.  Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Rehabilitation services</u>	\$30 <u>copay</u> /visit for NYP Affiliated Specialist; except no charge for office surgery \$40 <u>copay</u> /visit for non-NYP specialist; except no charge for office surgery	Physical Therapy Only:  <u>Deductible</u> + 30% <u>coinsurance</u>	60 visits/calendar year for In-Network and Out-of-Network Physical Therapy combined.  30 visits/calendar year for Speech & Occupational Therapy In-Network only combined, including outpatient hospital services.  Speech and Occupational Therapy are not covered for Out-of-Network Services
	<u>Habilitation services</u>	\$25 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Physical Therapy Only:  <u>Deductible</u> + 30% <u>coinsurance</u>	Speech and Occupational Therapy are not covered for Out-of-Network Services
	<u>Skilled nursing care</u>	No charge	<u>Deductible</u> + 30% <u>coinsurance</u>	60 days/calendar year.  Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Durable medical equipment</u>	No charge	<u>Deductible</u> + 30% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.  Includes Electric Breast Pumps limited to 1 per 12 months.
	<u>Hospice services</u>	No charge	<u>Deductible</u> + 30% <u>coinsurance</u>	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.

## Excluded Services & Other Covered Services:

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

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Prescription drugs
- 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.)

- Acupuncture
- Bariatric surgery - Limited to Institutes of Quality contracted facility for in-network only..
- NYP Virtual Urgent Care
- Gender Affirming Care
- Chiropractic care
- Hearing aids - \$6,000 maximum/3 years.
- Routine Eye Care 1 routine medical eye exam/calendar year. Refer to <https://nyp.aetna.com/> under Plan Offerings and select Vision plan for a detailed list of additional vision benefits.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition, artificial insemination & ovulation induction. Advanced Reproductive Technology (subject to coinsurance) \$30,000 maximum/lifetime at specific NYP facilities and Aetna® Institutes of Excellence™. Includes: IVF, cryopreservation, storage, thawing (for eggs, sperm and embryo). For Infertility related questions and additional details on infertility benefits please reach out to NIU at 1-800-575-5999 once enrolled.

**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 1-888-982-3862.
- 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 [www.cciio.cms.gov](http://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](http://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 number



at 1-888-982-3862. 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 [www.cciio.cms.gov](http://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.**

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? No.**

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 \$0
- Specialist copayment \$40
- Hospital (facility) copayment \$0
- Other copayment \$0

**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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
<b>In this example, Peg would pay:</b>	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$40
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
<b>The total Peg would pay is</b>	<b>\$40</b>

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

- The plan's overall deductible \$0
- Primary care copayment \$50
- Hospital (facility) copayment \$150
- Other copayment \$0

**This EXAMPLE event includes services like:**

- Primary care physician office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs
- Diabetic supplies (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
<b>In this example, Joe would pay:</b>	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
<b>The total Joe would pay is</b>	<b>\$200</b>

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

- The plan's overall deductible \$0
- Specialist copayment \$120
- Hospital (facility) copayment \$150
- Other copayment \$0

**This EXAMPLE event includes services like:**

- Emergency room care (*including medical supplies*)
- Diagnostic test (*x-ray*)
- Durable medical equipment (*crutches*)
- Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
<b>In this example, Mia would pay:</b>	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$270
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
<b>The total Mia would pay is</b>	<b>\$270</b>

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

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.

**Cynthia is Undergoing a Breast Augmentation in an Outpatient Setting**

(A year of in-network clinically assisted gender affirming in accordance with the plan generals)

- **The plan's overall deductible** **\$0**
- **Specialist copayment** **\$40**
- **Hospital (facility) copayment** **\$150**
- **Other copayment** **\$0**

**This EXAMPLE event includes services like:**

Primary care physician office visits (*including disease education*)

Diagnostic tests (*blood work*)

Prescription drugs

Durable medical equipment

<b>Total Example Cost</b>	<b>\$17,500</b>
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**In this example, Cynthia would pay:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$190
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
<b>The total Cynthia would pay is</b>	<b>\$190</b>

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 1-888-982-3862.

### **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), 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 companies, including Aetna Life Insurance Company and its affiliates (Aetna).**

TTY: 711

**Language Assistance:**

To access language services at no cost to you, call 1-888-982-3862.

- Albanian - Për shërbime përkthimi falas për ju, telefononi 1-888-982-3862.
- Amharic - የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-888-982-3862 ይደውሉ።
- Arabic - للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-888-982-3862
- Armenian - Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-888-982-3862 հեռախոսահամարով:
- Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya.
- Bantu-Kirundi - Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-888-982-3862.
- Bengali-Bangala - আপনাকে বিনামূল্যে ভাষা পবিকষা পপকে হকয এই নম্বকি পেবযক ান েরন: 1-888-982-3861
- Bisayan-Visayan - Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-888-982-3862.
- Burmese - သငို့အေချအဖို့ အခေယကေးငြ မေပးရဲပဲ ဘာသာစကားဝန်ဆောင်မား ရရှိဖို့ငွန် 1-888-982-3862 သို့ ဖုန်းခေခငှဆိုပါ။
- Catalan - Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-888-982-3862.
- Chamorro - Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-888-982-3862.
- Cherokee - Ⴀႃ႗ႃ Ⴀႃ႗ႃ႗ႃ Ⴀႃ႗ႃ႗ႃ Ⴀႃ႗ႃ Ⴀႃ႗ႃ Ⴀႃ႗ႃ႗ႃ Ⴀႃ႗ႃ Ⴀႃ႗ႃ႗ႃ႗ႃ 1-888-982-3862.
- Chinese - 如欲使用免費語言服務，請致電 1-888-982-3862.
- Choctaw - Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-888-982-3862.
- Cushite - Tajaajiloota afaanii garuu bilisaa ati argaachuuf, bilibili 1-888-982-3862.
- Dutch - Voor gratis toegang tot taaldiensten, bell 1-888-982-3862.
- French - Afin d'accéder aux services langagiers sans frais, composez le 1-888-982-3862.
- French Creole - Pou jwenn sèvis lang gratis, rele 1-888-982-3862.
- German - Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-888-982-3862 an.
- Greek - Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-888-982-3862.

- Gujarati - તમારેકોઇ જાતના ખર્ચવિના ભાષાની સેવાઓની પહોર માટે, કોલ કરો 1-888-982-3862.
- Hawaiian - No ka wala'au 'ana me ka lawelawe 'olelo e kahea aku i kēia helu kelepona 1-888-982-3862. Kāki 'ole 'ia kēia kōkua nei.
- Hindi - आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए, 1-888-982-3862 पर कॉल करें।
- Hmong - Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-888-982-3862.
- Igbo - Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ 1-888-982-3862
- Ilocano - Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-888-982-3862.
- Indonesian - Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-888-982-3862.
- Italian - Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-888-982-3862.
- Japanese - 言語サービスを無料でご利用いただくには、1-888-982-3862 までお電話ください。
- Karen - လာတၢ်ကမၤန့ၢ်ကိၣ်အတၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖၣ်လၢတအိၣ်ဒီးအပူၤလၢကဘၣ်ဟ့ၣ်အိၣ်အဂီၢ်ဘၣ်န့ၣ် ကိး 1-888-982-3862 တက့ၢ်.
- Korean - 무료 언어 서비스를 이용하려면 1-888-982-3862 번으로 전화해 주십시오.
- Kru-Bassa - M̈ d̈yi wuɖu-dù kà kò d̈ò b̈ě d̈yi m̈óú n̈ ní Pídyi ní, níí, d̈á n̈òb̈à n̈ià k̈e: 1-888-982-3862
- Kurdish - 1-888-982-3862 بۆ دەسپێرێکەشتن بە خزمەتگۆزاری زمان بەی تێچوون بۆ تۆ، پەیمۆندی بکە بە ژمارەى
- Laotian - ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ1-888-982-3862
- Marathi - कोणत्याही शक्ालशवाय भाषा सेवा प्राप्त करण्यासाठी,, 1-888-982-3862 वर फोन करा.
- Marshallese - Nan etal nan jiban ijiken Kajin ilo an ejelok onen nan kwe, kirlok 1-888-982-3862.
- Micronesian - Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-888-982-3862.
- Pohnpeyan - 1-888-982-3862 ເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ1-888-982-3862
- Mon-Khmer, Cambodian - ដើម្បីទទួលបានសេវាកម្មភាសាដោយឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-888-982-3862។
- Navajo - T'áá ni nizaad k'ehjí bee níká a'doowoł doo bááh ílínígóó koji' hólne' 1-888-982-3862.
- Nepali - निःशुल्क भाषा सेवा प्राप्त गर्न 1-888-982-3862 मा टेलिफोन गर्नुहोस् ।
- Nilotic-Dinka - Të koor yin wëċř de thokic ke cĳn wëu kōr keek tēnōŋ yĳn. Ke cōl kōc ye kōc kuōny ne nōmba 1-888-982-3862.
- Norwegian - For tilgang til kostnadsfri språktjenester, ring 1-888-982-3862.
- Pennsylvania Dutch - Um Schprooch Services zu griege mitaus Koscht, ruff 1-888-982-3862.
- Persian - برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-888-982-3862 تماس بگیرید .
- Polish - Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-888-982-3862.

