**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay for Covered Services

**Coverage Period: 07/01/2017 - 06/30/2018**

aetna : STATE OF IL STATE PPO : Aetna Choice® POS II - State of Illinois PPO LGHP

**Coverage for:** Individual + Family | **Plan Type:** POS

**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, **www.HealthReformPlanSBC.com** or by calling **1-800-370-4526**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at **https://www.healthcare.gov/sbc-glossary/** or call 1-800-370-4526 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | For each Plan Year, In-Network: Individual $750/ each individual must meet the individual deductible. | 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. Prescription drugs; plus in-network 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?** | Per your plan there are other specific deductibles. Please refer to your Summary Plan Description for this information. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | In-Network: Individual $1,750 / Family $3,500 Out-of–Network: Individual $4,750 / Family $9,500. | 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, penalties for failure to obtain pre-authorization for services & health care this plan doesn't cover. | 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 www.aetna.com/docfind or call 1-800-370-4526 for a list of in-network providers. | 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 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 | 10% coinsurance | 40% coinsurance | None |
| | Specialist visit | 10% coinsurance | 40% coinsurance | None |
| | Preventive care / screening / immunization | No charge | 40% coinsurance | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 10% coinsurance | 40% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance | 40% coinsurance | None |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.caremark.com | Generic drugs | Deductible doesn't apply, 30 day supply: $12.50, 90 day supply: $25.00 | Deductible doesn't apply, *30 day supply: $12.50, *90 day supply: $25.00, *less the negotiated in-network discount | Covers 30 day supply (retail), 61-90 day supply (mail order/maintenance). Your plan uses a preferred drug list which identifies the status of covered drugs. Some drugs may required pre-authorization. If necessary pre-authorization is not obtained, the drug may not be covered. Certain items identified by your plan as preventive care are covered in full not subject to the copayment amount indicated. You pay the difference in cost if you request a brand name drug instead of its generic equivalent plus the copayment. |
| | Preferred brand drugs | Deductible doesn't apply, 30 day supply: $25.00, 90 day supply: $50.00 | Deductible doesn't apply, *30 day supply: $25.00, *90 day supply: $50.00, *less the negotiated in-network discount | |
| | Non-preferred brand drugs | Deductible doesn't apply, 30 day supply: $50.00, 90 day supply: $100.00 | Deductible doesn't apply, *30 day supply: $50.00, *90 day supply: $100.00, *less the negotiated in-network discount | |

| 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) | |
| | Specialty drugs | Deductible doesn't apply, 30 day supply: $100.00, 90 day supply: $200.00 | Deductible doesn't apply, *30 day supply: $100.00, *90 day supply: $200.00, *less the negotiated in-network discount | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 40% coinsurance | None |
| | Physician/surgeon fees | 10% coinsurance | 40% coinsurance | None |
| **If you need immediate medical attention** | Emergency room care | 10% coinsurance after $400 copay/visit | 10% coinsurance after $400 copay/visit | $400/visit for in-network & out-of-network emergency room visit. Per visit co-pay is waived if admitted. |
| | Emergency medical transportation | 10% coinsurance | 10% coinsurance | None |
| | Urgent care | 10% coinsurance | 10% coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% coinsurance after $250 copay/stay | 40% coinsurance after $500 copay/stay | $250/admission for in-network hospital stay, $500/admission for out-of-network hospital stay. Pre-authorization required for out-of-network care. |
| | Physician/surgeon fees | 10% coinsurance | 40% coinsurance | None |
| **If you need mental health, behavioral health, or substance abuse services Coverage for these services is administered by magellanhealth.com.** | Outpatient services | Office & other outpatient services: 10% coinsurance | Office & other outpatient services: 40% coinsurance | Mental Health & Substance Abuse benefits not provided by Aetna. Contact Magellan 800-513-2611 |
| | Inpatient services | 10% coinsurance after $250 copay/stay | 40% coinsurance after $500 copay/stay | $250/admission for in-network hospital stay, $500/admission for out-of-network hospital stay. |

| 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 | 10% coinsurance | 40% coinsurance | Cost sharing doesn't apply to certain preventive services. Maternity care may include tests & services described elsewhere in the SBC (i.e. ultrasound). $250/admission for in-network hospital stay, $500/admission for out-of-network hospital stay. Pre-authorization required for out-of-network care may apply. |
| | Childbirth/delivery professional services | 10% coinsurance | 40% coinsurance | |
| | Childbirth/delivery facility services | 10% coinsurance after $250 copay/stay | 40% coinsurance after $500 copay/stay | |
| **If you need help recovering or have other special health needs** | Home health care | 10% coinsurance | 40% coinsurance | Custodial care not covered. Pre-authorization required for out-of-network care. |
| | Rehabilitation services | 10% coinsurance | 40% coinsurance | None |
| | Habilitation services | Not covered | Not covered | Not covered. |
| | Skilled nursing care | 10% coinsurance | 40% coinsurance | 100 days/annual max. Custodial care not covered. Pre-authorization required for out-of-network care. |
| | Durable medical equipment | 10% coinsurance | 40% coinsurance | None |
| | Hospice services | 10% coinsurance | 40% coinsurance | Pre-authorization required for out-of-network care. |
| **If your child needs dental or eye care** | Children's eye exam | Not covered | Not covered | Not covered. |
| | 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.)**

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Hearing aids
- Long-term care
- Private-duty nursing
- Routine eye care (Adult & Child)
- 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<br>• Chiropractic care - 30 visits/plan year. | • Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition. | • Non-emergency care when traveling outside the U.S. |

## 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 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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.
- 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 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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.
- 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 Standard? **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** **$750**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

**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:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $750 |
| Copayments | $0 |
| Coinsurance | $1,000 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1,810** |

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$750**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

**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:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $750 |
| Copayments | $1,000 |
| Coinsurance | $40 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,810** |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$750**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

**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:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $750 |
| Copayments | $0 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$850** |

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

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 1-800-370-4526.

## Smartphone or Tablet

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

## Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not 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.

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TTY: 711

**Language Assistance:**

For language assistance in your language call 1-800-370-4526 at no cost.

| | |
|---|---|
| Albanian - | Për asistencë në gjuhën shqipe telefononi falas në 1-800-370-4526. |
| Amharic - | ለቋንቋ እገዛ በ አማርኛ በ 1-800-370-4526 በነጻ ይደውሉ |
| Arabic - | للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-370-4526 |
| Armenian - | Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-800-370-4526 առանց գնով: |
| Bahasa Indonesia - | Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya. |
| Bantu-Kirundi - | Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-800-370-4526 ku busa |
| Bengali-Bangala - | বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-800-370-4526-তে কল করুন। |
| Bisayan-Visayan - | Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-370-4526 nga walay bayad. |
| Burmese - | ဌာနေကျန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-800-370-4526 ကို ခေါ်ဆိုပါ။ |
| Catalan - | Per rebre assistència en (català), truqui al número gratuït 1-800-370-4526. |
| Chamorro - | Para ayuda gi fino' (Chamoru), ågang 1-800-370-4526 sin gåstu. |
| Cherokee - | ᏥᏍᎩᏥ ᏚᏳᏂᏱᏍᏗ ᏗᏂᏍᏚᏅᏍᎩ ᏥᏄᏖ (ᏣᎳᎩ) ᏭᏂᏔᏛᏁᏚ 1-800-370-4526 ᎤᏥᏖ ᏧᏁᏍᏗ ᏑᏉᏅᏅᏗ ᏂᏣᏅᏥ. |
| Chinese - | 欲取得繁體中文語言協助，請撥打 1-800-370-4526，無需付費。 |
| Choctaw - | (Chahta) anumpa ya apela a chi l paya hinla 1-800-370-4526. |
| Cushite - | Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-800-370-4526 irratti bilisaan bilbilaa. |
| Dutch - | Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-370-4526. |
| French - | Pour une assistance linguistique en français appeler le 1-800-370-4526 sans frais. |
| French Creole - | Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-370-4526 gratis. |
| German - | Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-370-4526 an. |
| Greek - | Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-370-4526 χωρίς χρέωση. |
| Gujarati - | ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-800-370-4526 પર કૉલ કરો. |

| | |
|---|---|
| Hawaiian - | No ke kōkua ma ka ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-800-370-4526. Kāki ʻole ʻia kēia kōkua nei. |
| Hindi - | हिन्दी में भाषा सहायता के लिए, 1-800-370-4526 पर मुफ्त कॉल करें। |
| Hmong - | Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-370-4526. |
| Ibo - | Maka enyemaka asụsụ na Igbo kpọọ 1-800-370-4526 na akwụghị ụgwọ ọ bụla |
| Ilocano - | Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-370-4526 nga awan ti bayadanyo. |
| Italian - | Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-370-4526. |
| Japanese - | 日本語で援助をご希望の方は、1-800-370-4526 まで無料でお電話ください。 |
| Karen - | လၢတၢ်မၤစၢၤတၢ်ကတိၤကျိာ်အဂီၢ် ကျိာ် ကိး 1-800-370-4526 လၢတအိာ်ဒီးတၢ်လၢာ်ဘျာ်လၢာ်စ့ၤဘၣ် |
| Korean - | 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-370-4526번으로 전화해 주십시오. |
| Kru-Bassa - | Ɓɛ´m`ké gbo-kpá-kpá dyé piɗyi ɖé Ɓaɓɔɔ́-wuɖuǔn wɛɛ̃, ɖá 1-800-370-4526 |
| Kurdish - | برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 به خۆرایی پەیوەندی بکەن. |
| Laotian - | ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-800-370-4526 ໂດຍບໍ່ເສຍຄ່າໂທ. |
| Marathi - | तीलभाषा (मराठी) सहाय्यासाठी 1-800-370-4526 क्रमांकावरकोणत्याहीखर्चाशवायकॉलकरा. |
| Marshallese - | Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-370-4526 ilo ejjelok wōnān. |
| Micronesian-Pohnpeyan - | Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-370-4526 ni sohte isais. |
| Mon-Khmer, Cambodian - | សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-800-370-4526 ដោយឥតគិតថ្លៃ។ |
| Navajo - | T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-800-370-4526 |
| Nepali - | (नेपाली) मा नःिशुल्क भाषा सहायता पाउनका लागि 1-800-370-4526 मा फोन गर्नुहोस् । |
| Nilotic-Dinka - | Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-800-370-4526 kecïn aɣöc. |
| Norwegian - | For språkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt. |
| Panjabi - | ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-370-4526 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ। |
| Pennsylvania Dutch - | Fer Helfe in Deitsch, ruf: 1-800-370-4526 aa. Es Aaruf koschtet nix. |
| Persian - | برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 بدون هیچ هزینه ای تماس بگیرید. انگلیسی |
| Polish - | Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-370-4526. |

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| Portuguese - | Para obter assistência linguística em português ligue para o 1-800-370-4526 gratuitamente. |
| Romanian - | Pentru asistenţă lingvistică în româneşte telefonaţi la numărul gratuit 1-800-370-4526 |
| Russian - | Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-370-4526. |
| Samoan - | Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-800-370-4526 e aunoa ma se totogi. |
| Serbo-Croatian - | Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-370-4526. |
| Spanish - | Para obtener asistencia lingüística en español, llame sin cargo al 1-800-370-4526. |
| Sudanic-Fulfude - | Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-800-370-4526. Njodi woo fawaaki on. |
| Swahili - | Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-370-4526 bila malipo. |
| Syriac - | ܐܢ ܡܨܪܝܟ ܐܢ ܬܬܝܠܦ ܥܠܝܢ ܡܢ ܩܪܝܢܐ ܕܠܫܢܐ ܐܪܡܝܐ ܡܢ ܠܘܩܡ ܡܢܝܢ ܕܠܝܬ ܚܘܠܦܐ 1-800-370-4526 ܠܘܩܡ. |
| Tagalog - | Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-370-4526 nang walang bayad. |
| Telugu - | భాషతో సహాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-800-370-4526 కు కాల్ చేయండి. (తెలుగు) |
| Thai - | สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-800-370-4526 ฟรีไม่มีค่าใช้จ่าย |
| Tongan - | Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-800-370-4526 ‘o ‘ikai hā tōtōngi. |
| Trukese - | Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-800-370-4526 nge esapw kamé ngonuk. |
| Turkish - | (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-800-370-4526. |
| Ukrainian - | Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-370-4526. |
| Urdu - | اردو میں مدد کے لیے مفت میں 1-800-370-4526 پر کال کریں |
| Vietnamese - | Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-800-370-4526. |
| Yiddish - | פאר שפראך הילף אין אידיש רופט 1-800-370-4526 פריי פון אפצאל. |
| Yoruba - | Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-800-370-4526 lái san owó kankan rárá. |