



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, go to [www.meritain.com](http://www.meritain.com) or call (800) 925-2272. 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 Meritain Health, Inc. at (800) 925-2272 to request a copy.

| Questions                                                                  | Answers                                                                                                                                                                       | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall deductible?</b>                                     | In-Network: Individual \$4,000 / Family \$8,000.<br>Out-of-Network: Individual \$5,500 / Family \$11,000.                                                                     | 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 policy, the overall family <u>deductible</u> must be met before the plan begins to pay.                                                                                                                                                                                                                                                                                      |
| <b>Are there services covered before you meet your deductible?</b>         | Yes. For Participating <u>providers</u> : <u>Preventive care</u> is covered before you meet your deductible.                                                                  | 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>                                              |
| <b>Are there other deductibles for specific services?</b>                  | No.                                                                                                                                                                           | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>What is the out-of-pocket limit for this plan?</b>                      | In-Network: Individual \$10,000 / Family \$15,000. Out-of-Network: Individual \$11,000 / Family \$22,000.                                                                     | 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> , the overall family <u>out-of-pocket limit</u> must be met.                                                                                                                                                                                                                                                                                                                                                    |
| <b>What is not included in the out-of-pocket limit?</b>                    | <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> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Will you pay less if you use a network provider?</b>                    | Yes. See <a href="http://www.aetna.com/docfind/custom/mymeritain">www.aetna.com/docfind/custom/mymeritain</a> or call (800) 343-3140 for a list of <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. |
| <b>Do you need a referral to see a specialist?</b>                         | No.                                                                                                                                                                           | You can see the <u>specialist</u> you choose without a <u>referral</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Is a Health Savings Account (HSA) available under this plan option?</b> | Yes.                                                                                                                                                                          | An HSA is an account that may be set up by you or your employer to help you plan for current and future health care costs. You may make contributions to the HSA up to a maximum amount set by the IRS.                                                                                                                                                                                                                                                                                                                                                       |



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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                    |                                                                            | Participating Provider (you will pay the least)                                 | Non-Participating Provider (you will pay the most)                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>If you visit a health care provider's office or clinic</b>                                                                                                                                      | Primary care visit to treat an injury or illness                           | 20% <u>coinsurance</u>                                                          | 50% <u>coinsurance</u>                                              | Includes virtual care visits. Your cost share may be different, depending on the <u>provider</u> rendering these services. Refer to your <u>plan</u> for more information.                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                    | <u>Specialist</u> visit                                                    | 20% <u>coinsurance</u>                                                          | 50% <u>coinsurance</u>                                              | Includes virtual care visits. Your cost share may be different, depending on the <u>provider</u> rendering these services. Refer to your <u>plan</u> for more information.                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                    | <u>Preventive care</u> / <u>screening</u> /immunization                    | No Charge                                                                       | Not Covered                                                         | 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.                                                                                                                                                                                                                                                                                                                                                                    |
| <b>If you have a test</b>                                                                                                                                                                          | <u>Diagnostic test</u> (x-ray, blood work)<br>Imaging (CT/PET scans, MRIs) | 20% <u>coinsurance</u><br>20% <u>coinsurance</u>                                | 50% <u>coinsurance</u><br>50% <u>coinsurance</u>                    | None<br><u>Pre-authorization</u> recommended for PET scans.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <b>prescription drug coverage</b> is available at <a href="http://www.caremark.com">www.caremark.com</a> | Generic drugs                                                              | <u>Copay/prescription</u> :<br>20% (30-day retail, 90-day retail or mail order) | <u>Copay/prescription</u> :<br>20% (30-day retail or 90-day retail) | Major medical <u>deductible</u> applies. Covers up to a 90-day supply (retail), 90-day supply (mail order), 30-day supply ( <u>specialty drugs</u> ). There is no charge or <u>deductible</u> for preventive drugs. You pay a 20% <u>copay</u> and the <u>deductible</u> doesn't apply for preventive maintenance drugs. All <u>specialty drugs</u> must be filled through the Specialty Pharmacy <u>Network</u> . Certain <u>specialty drugs</u> are eligible for <u>copay</u> assistance programs through CVS True Accumulation Program. |
|                                                                                                                                                                                                    | Preferred brand drugs                                                      | <u>Copay/prescription</u> :<br>20% (30-day retail, 90-day retail or mail order) | <u>Copay/prescription</u> :<br>20% (30-day retail or 90-day retail) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                    | Non-preferred brand drugs                                                  | <u>Copay/prescription</u> :<br>20% (30-day retail, 90-day retail or mail order) | <u>Copay/prescription</u> :<br>20% (30-day retail or 90-day retail) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                    | <u>Specialty drugs</u>                                                     | <u>Copay/prescription</u> :<br>20%                                              | Not Covered                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>If you have outpatient surgery</b>                                                                                                                                                              | <u>Facility fee</u> (e.g., ambulatory surgery center)                      | 20% <u>coinsurance</u>                                                          | 50% <u>coinsurance</u>                                              | <u>Pre-authorization</u> recommended.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                    | Physician/surgeon fees                                                     | 20% <u>coinsurance</u>                                                          | 50% <u>coinsurance</u>                                              | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |

| Common Medical Event                                                      | Services You May Need                     | What You Will Pay                               |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                               |
|---------------------------------------------------------------------------|-------------------------------------------|-------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                           | Participating Provider (you will pay the least) | Non-Participating Provider (you will pay the most) |                                                                                                                                                                                                                                                                                      |
| If you need immediate medical attention                                   | <u>Emergency room care</u>                | 20% <u>coinsurance</u>                          | 20% <u>coinsurance</u>                             | Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits.                                                                                                                                                                                      |
|                                                                           | <u>Emergency medical transportation</u>   | 20% <u>coinsurance</u>                          | 20% <u>coinsurance</u>                             | Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits.                                                                                                                                                                                      |
|                                                                           | <u>Urgent care</u>                        | 20% <u>coinsurance</u>                          | 50% <u>coinsurance</u>                             | None                                                                                                                                                                                                                                                                                 |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)        | 20% <u>coinsurance</u>                          | 50% <u>coinsurance</u>                             | <u>Pre-authorization</u> recommended.                                                                                                                                                                                                                                                |
|                                                                           | Physician/surgeon fees                    | 20% <u>coinsurance</u>                          | 50% <u>coinsurance</u>                             | None                                                                                                                                                                                                                                                                                 |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | 20% <u>coinsurance</u>                          | 50% <u>coinsurance</u>                             | Includes virtual care visits. Your cost share may be different, depending on the <u>provider</u> rendering these services. Refer to your <u>plan</u> for more information.                                                                                                           |
|                                                                           | Inpatient services                        | 20% <u>coinsurance</u>                          | 50% <u>coinsurance</u>                             | <u>Pre-authorization</u> recommended.                                                                                                                                                                                                                                                |
| If you are pregnant                                                       | Office visits                             | 20% <u>coinsurance</u>                          | 50% <u>coinsurance</u>                             | <u>Cost sharing</u> doesn't apply to certain <u>preventive services</u> . Maternity care may include tests & services described elsewhere in the SBC (i.e. ultrasound). <u>Pre-authorization</u> recommended after hospital stays in excess of 48 hrs. (vaginal delivery) or 96 hrs. |
|                                                                           | Childbirth/delivery professional services | 20% <u>coinsurance</u>                          | 50% <u>coinsurance</u>                             |                                                                                                                                                                                                                                                                                      |
|                                                                           | Childbirth/delivery facility services     | 20% <u>coinsurance</u>                          | 50% <u>coinsurance</u>                             |                                                                                                                                                                                                                                                                                      |
| If you need help recovering or have other special health needs            | <u>Home health care</u>                   | 20% <u>coinsurance</u>                          | 50% <u>coinsurance</u>                             | 130 visits/year. <u>Pre-authorization</u> recommended.                                                                                                                                                                                                                               |
|                                                                           | <u>Rehabilitation services</u>            | 20% <u>coinsurance</u>                          | 50% <u>coinsurance</u>                             | 20 visits/year each for Physical, Occupational, Speech, Cognitive, Respiratory/Pulmonary and Massage Therapy combined. 36 visits/year for Cardiac Rehab. 30 visits/year for Post-Cochlear Implant Aural Therapy.                                                                     |
|                                                                           | <u>Habilitation services</u>              | 20% <u>coinsurance</u>                          | 50% <u>coinsurance</u>                             | None                                                                                                                                                                                                                                                                                 |
|                                                                           | <u>Skilled nursing care</u>               | 20% <u>coinsurance</u>                          | 50% <u>coinsurance</u>                             | 60 days/year. <u>Pre-authorization</u> recommended.                                                                                                                                                                                                                                  |
|                                                                           | <u>Durable medical equipment</u>          | 20% <u>coinsurance</u>                          | 50% <u>coinsurance</u>                             | <u>Pre-authorization</u> recommended.                                                                                                                                                                                                                                                |
|                                                                           | <u>Hospice services</u>                   | 20% <u>coinsurance</u>                          | 50% <u>coinsurance</u>                             | None                                                                                                                                                                                                                                                                                 |
|                                                                           |                                           |                                                 |                                                    |                                                                                                                                                                                                                                                                                      |
| 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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Glasses (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing - Except for home health care & hospice.
- Routine eye care (Adult)
- Routine foot care - Except for metabolic or peripheral vascular disease, including diabetes.
- Weight loss programs

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

- Acupuncture - 12 visits/year.
- Chiropractic care - 20 visits/year.
- Hearing aids - \$3,000 per impaired ear/36 months; limited to a single purchase per impaired ear/36 months.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition; 1 cycle up to \$20,000/lifetime for fertility preservation for iatrogenic infertility only (combined with PGT).

**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 (800) 925-2272.
- 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 the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**Does this plan provide Minimum Essential Coverage? Yes.**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet Minimum Value Standards? Yes.**

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

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

## About these Coverage Examples:



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

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

|                                               |         |
|-----------------------------------------------|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$4,000 |
| ■ <u>Primary care physician coinsurance</u>   | 20%     |
| ■ <u>Hospital (facility) coinsurance</u>      | 20%     |
| ■ <u>Other coinsurance</u>                    | 20%     |

#### This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
Diagnostic tests (*ultrasounds and blood work*)  
Specialist visit (*anesthesia*)

|                                        |                 |
|----------------------------------------|-----------------|
| <b>Total Example Cost</b>              | <b>\$12,700</b> |
| <b>In this example, Peg would pay:</b> |                 |
| <u>Cost Sharing</u>                    |                 |
| <u>Deductibles</u>                     | \$4,000         |
| <u>Copayments</u>                      | \$0             |
| <u>Coinsurance</u>                     | \$1,500         |
| <u>What isn't covered</u>              |                 |
| Limits or exclusions                   | \$60            |
| <b>The total Peg would pay is</b>      | <b>\$5,560</b>  |

### Managing Joe's Type 2 Diabetes

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

|                                               |         |
|-----------------------------------------------|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$4,000 |
| ■ <u>Specialist coinsurance</u>               | 20%     |
| ■ <u>Hospital (facility) coinsurance</u>      | 20%     |
| ■ <u>Other coinsurance</u>                    | 20%     |

#### This EXAMPLE event includes services like:

Primary care provider 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>                     | \$4,000        |
| <u>Copayments</u>                      | \$0            |
| <u>Coinsurance</u>                     | \$300          |
| <u>What isn't covered</u>              |                |
| Limits or exclusions                   | \$20           |
| <b>The total Joe would pay is</b>      | <b>\$4,320</b> |

### Mia's Simple Fracture

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

|                                               |         |
|-----------------------------------------------|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$4,000 |
| ■ <u>Specialist coinsurance</u>               | 20%     |
| ■ <u>Hospital (facility) coinsurance</u>      | 20%     |
| ■ <u>Other coinsurance</u>                    | 20%     |

#### This EXAMPLE event includes services like:

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

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

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

TTY: 711

### Language Assistance:

To access language services at no cost to you, call (800) 925-2272.

|                    |                                                                                                                             |
|--------------------|-----------------------------------------------------------------------------------------------------------------------------|
| Albanian -         | Për shërbime përkthimi falas për ju, telefononi (800) 925-2272.                                                             |
| Amharic -          | የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ (800) 925-2272 ይደውሉ።                                                                           |
| Arabic -           | للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم (800) 925-2272                                            |
| Armenian -         | Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք (800) 925-2272 հեռախոսահամարով:                                 |
| Bahasa Indonesia - | Untuk bantuan dalam bahasa Indonesia, silakan hubungi (800) 925-2272 tanpa dikenakan biaya.                                 |
| Bantu-Kirundi -    | Kugira uronke serivisi z'indimi atakiguzi, hamagara (800) 925-2272.                                                         |
| Bengali-Bangala -  | আপনাকে বিনামূল্যে ভাষা পবিকষিা পপকে হকয এই নম্বকি পেবযক ান েরন: (800) 925-2272 ।                                            |
| Bisayan-Visayan -  | Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa (800) 925-2272.                                       |
| Burmese -          | သင့်အနေဖြင့် အခမဲ့စကားပြော မေးရပဲ ဘာသာစကားဝန်ဆောင်ခန်း ရရှိလိုက်နာ (800) 925-2272 သို့မဟုတ် ဖုန်းခေါ်ဆိုပါ။                 |
| Catalan -          | Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al (800) 925-2272.                                     |
| Chamorro -         | Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang (800) 925-2272.                                             |
| Cherokee -         | Ⴄႃ႗ႃႉ Ⴑ႗႗႗႗႗ Ⴑ႗႗႗႗႗ Ⴑ႗႗႗႗႗ Ⴑ႗႗႗႗႗ Ⴑ႗႗႗႗႗ Ⴑ႗႗႗႗႗ Ⴑ႗႗႗႗႗ (800) 925-2272.                                                      |
| Chinese -          | 如欲使用免費語言服務，請致電 (800) 925-2272.                                                                                              |
| Choctaw -          | Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya (800) 925-2272.                                          |
| Cushite -          | Tajaajiloota afaanii garuu bilisaa ati argaachuuf,bilbili (800) 925-2272.                                                   |
| Dutch -            | Voor gratis toegang tot taaldiensten, bell (800) 925-2272.                                                                  |
| French -           | Afin d'accéder aux services langagiers sans frais, composez le (800) 925-2272.                                              |
| French Creole -    | Pou jwenn sèvis lang gratis, rele (800) 925-2272.                                                                           |
| German -           | Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie (800) 925-2272 an.                                  |
| Greek -            | Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό (800) 925-2272. |
| Gujarati -         | તમારેકોઇ જાતના ખર્ચવિના ભાષાની સેવાઓની પહોંર માટે, કોલ કરો 1-888-982-3862.                                                  |

|                             |                                                                                                                         |
|-----------------------------|-------------------------------------------------------------------------------------------------------------------------|
| Hawaiian -                  | No ka wala‘au ‘ana me ka lawelawe ‘ōlelo e kahea aku i kēia helu kelepona (800) 925-2272. Kāki ‘ole ‘ia kēia kōkua nei. |
| Hindi -                     | आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए,(800) 925-2272 पर कॉल करें।                                      |
| Hmong -                     | Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu (800) 925-2272.                                               |
| Igbo -                      | Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ (800) 925-2272                                                             |
| Ilocano -                   | Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti (800) 925-2272.                 |
| Indonesian -                | Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi (800) 925-2272.                                           |
| Italian -                   | Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero (800) 925-2272.                        |
| 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 -                     | လၢတၢ်ကမၤန့ၢ်ကျိၣ်အတၢ်မၤစၢၤအတၢ်ဖဲးတၢ်မၤတဖၣ်လၢတၢ်အိၣ်ဒီးအပူၤလၢကဘၣ်ဟ့ၣ်အိၣ်အဂီၢ်ဘၣ်န့ၣ် ကိး (800) 925-2272 တက့ၢ်.          |
| Korean -                    | 무료 언어 서비스를 이용하려면 (800) 925-2272 번으로 전화해 주십시오.                                                                           |
| Kru-Bassa -                 | M̈ dyi wuḍu-dù kà kò ḍò bě dyi m̈oú ḥ n̈ì Pídyi ní, n̈íí, ḍá n̈òbà n̈à k̈e: (800) 925-2272                             |
| Kurdish -                   | بۆ دەستگیر ئەگەشتن بە خزمەتگوزاری زمان بەبێ تێچوون بۆ تۆ، پەیوەندی بکە بە ژمارەی (800) 925-2272                         |
| Laotian -                   | ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ (800) 925-2272                                            |
| Marathi -                   | कोणत्याही शल्ुकालशवाय भाषा सेवा प्राप्त करण्यासाठी,, (800) 925-2272 वर फोन करा.                                         |
| Marshallese -               | Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok (800) 925-2272.                                |
| Micronesian-<br>Pohnpeyan - | Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih (800) 925-2272.                                             |
| Mon-Khmer,<br>Cambodian -   | ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ (800) 925-2272 ។                             |
| Navajo -                    | T’áá ni nizaad k’ehjí bee níká a’dowoł doo báąh ílínígóó koji’ hólne’ (800) 925-2272.                                   |
| Nepali -                    | निःशुल्क भाषा सेवा प्राप्त गर्न (800) 925-2272 मा टेलिफोन गर्नुहोस् ।                                                   |
| Nilotic-Dinka -             | Të koor yin wëër de thokic ke cîn wëu ḳor keek ṭenon̄ yîn. Ke c̣ol ḳoc ye ḳoc kuony ne nomba (800) 925-2272.        |
| Norwegian -                 | For tilgang til kostnadsfri språktjenester, ring (800) 925-2272.                                                        |
| Pennsylvania Dutch -        | Um Schprooch Services zu griege mitaus Koscht, ruff (800) 925-2272.                                                     |
| Persian -                   | برای دسترسی به خدمات زبان به طور رایگان، با شماره (800) 925-2272 تماس بگیرید .                                          |
| Polish -                    | Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć (800) 925-2272.                                     |
| Portuguese -                | Para acessar os serviços de idiomas sem custo para você, ligue para (800) 925-2272.                                     |

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| Punjabi -         | ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, (800) 925-2272 'ਤੇ ਫ਼ੋਨ ਕਰੋ।                      |
| Romanian -        | Pentru a accesa gratuit serviciile de limbă, apălați (800) 925-2272.                                              |
| Russian -         | Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону (800) 925-2272.                       |
| Samoan -          | Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le (800) 925-2272.                              |
| Serbo-Croatian -  | Za besplatne prevodilačke usluge pozovite (800) 925-2272.                                                         |
| Spanish -         | Para acceder a los servicios de idiomas sin costo, llame al (800) 925-2272.                                       |
| Sudanic-Fulfude - | Heeba a nasta jangirde djey wolde wola chede bo apelou lamba (800) 925-2272.                                      |
| Swahili -         | Kupata huduma za lugha bila malipo kwako, piga (800) 925-2272.                                                    |
| Syriac -          | ܝܥܢ ܡܠܟܐ, ܕܠ ܝܠܝܟܝܐ ܠܚܝܬܐ ܠܝܥܬܐ ܕܝܠܝܟܝܐ, ܡܢ ܡܢܝܚܐ: (800) 925-2272                                                 |
| Tagalog -         | Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa (800) 925-2272.                    |
| Telugu -          | మీరు భాష సేవలను ఉచితంగా అందుకునందుకు, (800) 925-2272 కు కాల్ చేయండి.                                              |
| Thai -            | หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร (800) 925-2272.                               |
| Tongan -          | Kapau 'oku ke fiema'u ta'etōtōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he (800) 925-2272. |
| Trukese -         | Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori (800) 925-2272.                              |
| Turkish -         | Sizin için ücretsiz dil hizmetlerine erişebilmek için, (800) 925-2272 numarayı arayın.                            |
| Ukrainian -       | Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером (800) 925-2272.                          |
| Urdu -            | بالقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، (800) 925-2272 پر بات کریں۔                                       |
| Vietnamese -      | Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số (800) 925-2272.                             |
| Yiddish -         | צו צוטריט שפראך באדינונגען אין קיין פרייז צו איר, רופן (800) 925-2272                                             |
| Yoruba -          | Lati wọnú awọn isẹ èdè l'ọfẹ fun ọ, pe (800) 925-2272.                                                            |